

EXHIBIT I

Vladimir Iakovlev, M.D.

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

IN RE: BOSTON SCIENTIFIC CORP., MDL NO.: 2326
PELVIC REPAIR SYSTEM
PRODUCTS LIABILITY LITIGATION

THIS DOCUMENT RELATES TO:

Chapa v. Boston Scientific Corporation	2:13-cv-17511
Fisher v. Boston Scientific Corporation	2:13-cv-29324
Flandro v. Boston Scientific Corporation	2:13-cv-17027

Toronto, Ontario, Canada

Wednesday, December 17, 2014

VOLUME I

Videotaped Deposition of VLADIMIR IAKOVLEV,
M.D., a witness herein, called for examination
by counsel for the Defendants in the above-mentioned
matter, the witness having been affirmed, taken at the
offices of Neesons Reporting, 141 Adelaide Street West,
Toronto, Ontario, at 9:11 a.m., on Wednesday, December 17,
2014, and the proceedings being taken down by Stenotype
and transcribed by JUDITH M. CAPUTO, RPR, CSR, CRR.

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<p>1 THIS DOCUMENT RELATES TO: (Cont'd)</p> <p>2</p> <p>3 Fleming v. Boston Scientific Corporation 2:12-cv-05131</p> <p>4 Franco v. Boston Scientific Corporation 2:12-cv-07248</p> <p>5 Hanson v. Boston Scientific Corporation 2:13-cv-10653</p> <p>6 Hoffman v. Boston Scientific Corporation 2:12-cv-04433</p> <p>7 Howard v. Boston Scientific Corporation 2:12-cv-04145</p> <p>8 Kilgore v. Boston Scientific Corporation 2:13-cv-09171</p> <p>9 Parker v. Boston Scientific Corporation 2:12-cv-01243</p> <p>10 Reynolds v. Boston Scientific Corporation 2:12-cv-09934</p> <p>11 Robbins v. Boston Scientific Corporation 2:12-cv-01413</p> <p>12 Tame v. Boston Scientific Corporation 2:13-cv-01059</p> <p>13 Watanabe v. Boston Scientific Corporation 2:13-cv-12227</p> <p>14</p> <p>15</p> <p>16 A P P E A R A N C E S:</p> <p>17</p> <p>18 ON BEHALF OF THE PLAINTIFFS:</p> <p>19 BY: JONATHAN D. ORENT, ESQ.</p> <p>20 Motley Rice, LLC</p> <p>21 321 South Main Street, 2nd Floor</p> <p>22 Providence, Rhode Island 02903</p> <p>23 401.457.7723</p> <p>24</p> <p>25</p>	<p>1 A P P E A R A N C E S: (Cont'd)</p> <p>2</p> <p>3 ON BEHALF OF THE PLAINTIFFS:</p> <p>4 BY: CRAIG EILAND, ESQ.</p> <p>5 Law Offices of Craig Eiland</p> <p>6 2211 The Strand, Suite 201</p> <p>7 Galveston, Texas 77550</p> <p>8 409.763.3260</p> <p>9</p> <p>10 ON BEHALF OF THE DEFENDANTS:</p> <p>11 BY: ADRIENNE L. BYARD, ESQ.</p> <p>12 Shook, Hardy & Bacon, LLP</p> <p>13 2555 Grand Boulevard</p> <p>14 Kansas City, Missouri 64108</p> <p>15 816.474.6550</p> <p>16</p> <p>17 ALSO PRESENT:</p> <p>18 DENNIS COSTIGAN, Motley Rice LLC</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>
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<p>1 A P P E A R A N C E S:</p> <p>2</p> <p>3 ON BEHALF OF THE PLAINTIFFS:</p> <p>4 BY: ALAN S. LAZAR, ESQ.</p> <p>5 Marlin Saltzman, LLP</p> <p>6 29229 Canwood Street, Suite 208</p> <p>7 Agoura Hills, California 91301</p> <p>8 818.991.8080</p> <p>9</p> <p>10 ON BEHALF OF THE PLAINTIFFS:</p> <p>11 BY: NATHAN C. BESS, ESQ.</p> <p>12 Aylstock, Witkin, Kreis & Overholtz</p> <p>13 17 East Main Street, Suite 200</p> <p>14 Pensacola, Florida 32502</p> <p>15 850.202.1010</p> <p>16</p> <p>17 ON BEHALF OF THE PLAINTIFFS:</p> <p>18 BY: KATY KROTTINGER, ESQ.</p> <p>19 The Monsour Law Firm</p> <p>20 404 North Green Street</p> <p>21 Longview, Texas 75606</p> <p>22 903.758.5757</p> <p>23</p> <p>24</p> <p>25</p>	<p>1 I N D E X</p> <p>2</p> <p>3 WITNESS: VLADIMIR IAKOVLEV, M.D.</p> <p>4 PAGE</p> <p>5 DIRECT EXAMINATION BY MS. BYARD.....8</p> <p>6</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p> <p>11 I N D E X O F E X H I B I T S</p> <p>12</p> <p>13 NUMBER/DESCRIPTION PAGE NO.</p> <p>14 1195: Notice of Videotaped Deposition 10</p> <p>15 Duces Tecum of Dr. Vladimir Iakovlev.</p> <p>16 1196: General Expert Report of 27</p> <p>17 Dr. Iakovlev dated November 10, 2014.</p> <p>18 1197: Article entitled, "Mesh-Related 80</p> <p>19 SIN Syndrome: A Surreptitious Irreversible</p> <p>20 Neuralgia and Its Morphologic Background</p> <p>21 in the Etiology of Post-Herniorrhaphy Pain,"</p> <p>22 International Journal of Clinical</p> <p>23 Medicine, 2014, by Dr. R. Bendavid,</p> <p>24 Dr. W. Lou, Dr. A. Koch and Dr. V. Iakovlev.</p> <p>25</p>

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<p>1 1198: International Scholarly and 156 2 Scientific Research & Innovation, 2014, 3 Publication entitled, "Pathology of 4 Explanted Transvaginal Meshes," by 5 Dr. V. Iakovlev, Dr. E. T. Carey and 6 Dr. J. Steege. 7 1199: Abstract entitled, "Pathological 186 8 Findings of Transvaginal Polypropylene 9 Slings Explanted for Late Complications: 10 Mesh is Not Inert," by Dr. V. Iakovlev, 11 Dr. G. Mekel and Dr. J. Blaivas. 12 1201: Abstract entitled, "In-vivo 207 13 Degradation of Surgical Polypropylene 14 Meshes: A Finding Overlooked for 15 Decades," by Dr. V. Iakovlev, 16 Dr. S. Guelcher, Dr. R. Bendavid. 17 18 19 20 21 22 23 24 25</p>	<p>1 Defendant, Boston Scientific. 2 MR. EILAND: Craig Eiland for the 3 Plaintiffs. 4 THE VIDEOGRAPHER: Thank you. 5 The court reporter is Judy Caputo, CSR, 6 and who will now swear in or affirm the witness. 7 Whereupon, 8 VLADIMIR IAKOVLEV, M.D., 9 called for examination by counsel for Defendants 10 and having been affirmed by me, was examined and 11 testified as follows: 12 DIRECT EXAMINATION BY MS. BYARD: 13 Q. Dr. Iakovlev, it's very nice to 14 see you again. You'll recall I'm Adrienne Byard. 15 I think the last time we had the opportunity to 16 talk was in January of 2014, when I took your 17 deposition here in Toronto. Do you remember that 18 deposition? 19 A. Yes, I do. 20 Q. And since that time you've been 21 deposed again; correct? 22 A. By Boston Scientific, yes. 23 Q. And also by other mesh 24 manufacturers, right? 25 A. Yes, that's correct.</p>
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<p>1 -- Upon commencing at 9:11 a.m. 2 3 THE VIDEOGRAPHER: Good morning. We 4 are now on the record. My name is Peter Goodale, 5 certified legal videographer for Golkow Technologies. 6 Today's date is December 17, 2014, and 7 the time on the video monitor is 9:11 a.m. 8 This video deposition is being held in 9 Toronto, Ontario, Canada in the matter of: In Re: 10 Boston Scientific Corporation Pelvic Repair System 11 Products Liability Litigation, for the United 12 States District Court, for the Southern District of 13 West Virginia, Charleston Division, MDL No. 2326. 14 The deponent is Dr. Vladimir Iakovlev. 15 Counsel, please identify yourselves and state who 16 you represent. 17 MR. ORENT: Jonathan Orent for the 18 Plaintiffs. 19 MR. LAZAR: Alan Lazar for the 20 Plaintiffs. 21 MR. BESS: Nathan Bess, also for the 22 Plaintiffs. 23 MS. KROTTINGER: Katy Krottinger for 24 the Plaintiffs. 25 MS. BYARD: And Adrienne Byard for</p>	<p>1 Q. Okay. And you've also had the 2 opportunity to testify at some trials; correct? 3 A. Yes. 4 Q. Let's work forwards in time. 5 So from January 2014, when I took your 6 deposition here in Toronto, when was your next 7 deposition? 8 A. I think I had one, either in 9 February, February 4th or somewhere in that date, 10 and there was another one in March -- 11 Q. Let me stop you there, if you 12 don't mind. Were those in an AMS matter? 13 A. Yes. 14 Q. And just one, one case, right? 15 A. What do you mean "one case"? 16 Q. Was it just -- were you just 17 looking at pathological specimens for a single 18 case, or were your opinions applying across 19 AMS cases; if you know? 20 A. There were a number of cases. 21 Q. Okay. And then when was your 22 next deposition? 23 A. From February 4th? 24 Q. Yes. February and March for AMS, 25 and then when was the next one?</p>

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<p>1 A. Then there was one for Ethicon in</p> <p>2 April.</p> <p>3 Q. Okay.</p> <p>4 A. But that's not a memory test. The</p> <p>5 recent depositions is provided on the flash drive</p> <p>6 for you.</p> <p>7 Q. Okay. So you've brought some</p> <p>8 materials with you here today through counsel in</p> <p>9 response to our request. Is that what you're</p> <p>10 saying?</p> <p>11 A. That's correct.</p> <p>12 Q. Okay. And we'll go ahead and mark</p> <p>13 as 1195, the Notice of Deposition. I'll pass a</p> <p>14 copy of that to you.</p> <p>15 EXHIBIT NO. 1195: Notice of Videotaped</p> <p>16 Deposition Duces Tecum of Dr. Vladimir</p> <p>17 Iakovlev.</p> <p>18 BY MS. BYARD:</p> <p>19 Q. Is this deposition notice, or one</p> <p>20 similar to it, familiar to you, sir?</p> <p>21 A. Yes.</p> <p>22 Q. And did you bring documents</p> <p>23 responsive to our request through counsel?</p> <p>24 A. Yes.</p> <p>25 Q. What were the documents, as far as</p>	<p>1 Q. You said "my obligations"?</p> <p>2 A. No, no, I didn't say that.</p> <p>3 Q. Oh, really? Okay, I missed it</p> <p>4 then. Somewhere between "medical records reviewed</p> <p>5 for Plaintiffs" and the "billing for Plaintiffs" --</p> <p>6 MR. ORENT: He said "publications."</p> <p>7 BY MS. BYARD:</p> <p>8 Q. "Publications." Publications,</p> <p>9 thank you so much.</p> <p>10 You'll remember the rules of the</p> <p>11 deposition, I'm sure, that if there are times when</p> <p>12 we don't understand each other, I'll ask for</p> <p>13 clarification and I'll ask that you do the same;</p> <p>14 all right?</p> <p>15 A. Sure.</p> <p>16 Q. If you don't ask for</p> <p>17 clarification, I'll assume you understood me, okay?</p> <p>18 A. (Witness nods).</p> <p>19 Q. Is that fair?</p> <p>20 A. Yes, that's fair.</p> <p>21 Q. Very good.</p> <p>22 What else was, besides your</p> <p>23 publications, the medical records you reviewed for</p> <p>24 Plaintiffs, and the billings for Plaintiffs, is on</p> <p>25 that thumb drive, so far as you know?</p>
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<p>1 you understand it, that were being brought here</p> <p>2 today in response to our request?</p> <p>3 A. Medical records I reviewed for the</p> <p>4 Plaintiffs. My publications, billing I produced</p> <p>5 for the Plaintiffs, which were identified in this</p> <p>6 notice.</p> <p>7 Q. Okay.</p> <p>8 A. For whatever reason, there is no</p> <p>9 list here. It looks different than what I</p> <p>10 received.</p> <p>11 Q. Right. The list you saw, and I'll</p> <p>12 just show you this -- we're not going to mark it at</p> <p>13 this point -- but it was a longer list like this,</p> <p>14 right?</p> <p>15 A. Yes. That looks more familiar</p> <p>16 than this.</p> <p>17 Q. Okay. And so you brought the</p> <p>18 billing that pertained to those women's cases,</p> <p>19 right?</p> <p>20 A. Um-hum.</p> <p>21 Q. Okay.</p> <p>22 A. Yes.</p> <p>23 Q. Now, when you say "obligations,"</p> <p>24 what do you mean by that?</p> <p>25 A. What do you mean?</p>	<p>1 A. The list of testimonies I gave.</p> <p>2 Q. Okay.</p> <p>3 A. My current CV.</p> <p>4 Q. You don't have a paper copy of</p> <p>5 that that I could review and go over with you now</p> <p>6 of any of those materials?</p> <p>7 A. No, I didn't bring them. I tried</p> <p>8 to save trees.</p> <p>9 Q. Okay. Well, we'll take that up on</p> <p>10 a break.</p> <p>11 I want to return to this list of</p> <p>12 depositions. So you gave a deposition in April or</p> <p>13 in that timeframe for Ethicon, have you given</p> <p>14 depositions in any cases involving any other</p> <p>15 manufacturers of transvaginal mesh?</p> <p>16 A. Yes.</p> <p>17 Q. Okay. Which others?</p> <p>18 A. Bard.</p> <p>19 Q. When was that deposition?</p> <p>20 A. Let me turn it up. The deposition</p> <p>21 for Bard was in November.</p> <p>22 Q. November. Now you've also</p> <p>23 testified at some trials; correct?</p> <p>24 A. That's correct.</p> <p>25 Q. What trials have you testified at</p>

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<p>1 and when were they?</p> <p>2 A. Both were for Boston Scientific</p> <p>3 devices. One trial was in August for Ms. Cardenas</p> <p>4 and the other one was in Miami for Ms. Eghanayem</p> <p>5 and other patients.</p> <p>6 Q. Going back to depositions, you</p> <p>7 also had -- besides the time that I took your</p> <p>8 deposition in January with Ms. Weiler for Boston</p> <p>9 Scientific, you also had a deposition in July,</p> <p>10 where you covered, specifically, the Cardenas and</p> <p>11 the Eghanayem matters, right?</p> <p>12 A. That's correct.</p> <p>13 Q. So all told, you've been deposed</p> <p>14 once in the Boston Scientific MDL; once for two</p> <p>15 specific cases in the Boston Scientific MDL; once</p> <p>16 for Ethicon --</p> <p>17 A. Twice.</p> <p>18 Q. Twice for Ethicon. Then a</p> <p>19 deposition for Bard?</p> <p>20 A. Twice for Bard.</p> <p>21 Q. Twice for Bard. And so we're in</p> <p>22 the neighborhood of six or seven depositions?</p> <p>23 A. That's correct.</p> <p>24 Q. And two trials?</p> <p>25 A. That's correct.</p>	<p>1 tissue and mesh samples, observed any differences</p> <p>2 that you believe would increase or decrease the</p> <p>3 risk of clinical complications in women, depending</p> <p>4 on the type of mesh that is used?</p> <p>5 MR. ORENT: Objection.</p> <p>6 THE WITNESS: Define "type." Different</p> <p>7 manufacturer, different device, different knit</p> <p>8 pattern? I mean, what, what exactly --</p> <p>9 BY MS. BYARD:</p> <p>10 Q. Any of those are fine. It's an</p> <p>11 open-ended question.</p> <p>12 A. In some lightweight meshes,</p> <p>13 there is more inclusion of normal tissue into the</p> <p>14 pores. The difference is not drastic, but there</p> <p>15 is -- at the same time, these lightweight meshes</p> <p>16 fold easier, so it defeats the purpose of the</p> <p>17 design.</p> <p>18 But theoretically, they're flat. They</p> <p>19 would behave better than those more heavier with</p> <p>20 less pores. I mean, there are drawbacks and cons</p> <p>21 and pros of this, but the design behaves slightly</p> <p>22 differently than other designs -- than heavier</p> <p>23 weight designs. That's what I can say.</p> <p>24 Q. So at this point, based on your</p> <p>25 observations to date, you're not in a position to</p>
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<p>1 Q. Because we've already covered so</p> <p>2 many of your opinions with you in these other</p> <p>3 depositions and at trials, I'm not going to rehash</p> <p>4 a bunch of old ground with you.</p> <p>5 I'd like to specifically cover with you</p> <p>6 today, your deposition for these wave cases, this</p> <p>7 general report that you've authored. It's roughly</p> <p>8 the 93-page report that was submitted in the wave</p> <p>9 cases, all right?</p> <p>10 And then I'd also like to cover with</p> <p>11 you some of the updates to your opinions, if any,</p> <p>12 okay, sir?</p> <p>13 A. (Witness nods.)</p> <p>14 Q. Has your opinion across these</p> <p>15 depositions and trials been basically the same?</p> <p>16 And by that I mean, that the tissue response that</p> <p>17 you see the polypropylene mesh is essentially</p> <p>18 similar across all the various manufacturers?</p> <p>19 MR. ORENT: Objection.</p> <p>20 THE WITNESS: Yes, to a degree. I</p> <p>21 learn a little bit more after examining more</p> <p>22 specimens, more details. But basic principles</p> <p>23 remain the same.</p> <p>24 BY MS. BYARD:</p> <p>25 Q. Have you in your observations of</p>	<p>1 say that those designs are safer or would minimize</p> <p>2 the risk of clinical complications in women, right?</p> <p>3 MR. ORENT: Objection.</p> <p>4 THE WITNESS: Not to a noticeable degree.</p> <p>5 BY MS. BYARD:</p> <p>6 Q. Okay.</p> <p>7 A. To detectable degree.</p> <p>8 I see they behave differently, the</p> <p>9 tissue reacts differently. But all of them came to</p> <p>10 me because of complications.</p> <p>11 Q. Right.</p> <p>12 A. So I ended up with specimens which</p> <p>13 are excised complications. Therefore,</p> <p>14 complications occurred in those.</p> <p>15 Q. And I believe you noted in one of</p> <p>16 your original reports, that there's mesh that has</p> <p>17 tangs and mesh that doesn't have tangs, comparing</p> <p>18 Boston Scientific mesh either between products or</p> <p>19 Boston Scientific mesh to other products; do you</p> <p>20 recall that distinction?</p> <p>21 A. Yes, there is distinction. I</p> <p>22 mean, some are tanged; heat treated them in slings,</p> <p>23 but they're not treated along all lengths. Some</p> <p>24 are shorter segment.</p> <p>25 So it also behaves somewhat differently.</p>

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<p style="text-align: right;">Page 18</p> <p>1 But the end result was they became excised, they</p> <p>2 were problematic.</p> <p>3 Q. So similarly, you're not in a</p> <p>4 position today, based on your observations to date,</p> <p>5 to testify that the tissue response to the</p> <p>6 de-tanged mesh versus tanged mesh, is better or</p> <p>7 worse in terms of its likelihood of causing</p> <p>8 complications in women, right?</p> <p>9 MR. ORENT: Objection.</p> <p>10 THE WITNESS: That is difficult</p> <p>11 question. I mean, you're asking likelihood. This</p> <p>12 would be more of a clinical question, and to be a</p> <p>13 clinical trial, larger trial.</p> <p>14 I can tell you that there is a</p> <p>15 different tissue reaction. And I can tell you that</p> <p>16 my specimens came to me because patients</p> <p>17 experienced complications.</p> <p>18 But I would not be able to give you a</p> <p>19 statement of what's the percentage of improvement</p> <p>20 or, or lack of improvement.</p> <p>21 BY MS. BYARD:</p> <p>22 Q. And you wouldn't be able to say</p> <p>23 that to a reasonable degree of certainty, right?</p> <p>24 MR. ORENT: Objection.</p> <p>25 THE WITNESS: I just wouldn't be able</p>	<p style="text-align: right;">Page 20</p> <p>1 after excision, or during in vivo?</p> <p>2 Q. Sure. So you're talking about the</p> <p>3 shape after excision; correct?</p> <p>4 A. That's correct.</p> <p>5 Q. Okay. And when you look at the</p> <p>6 shape after excision, you're not able to say with</p> <p>7 certainty, what the shape of the mesh was in vivo,</p> <p>8 typically, unless it's completely encased in scar</p> <p>9 tissue, right?</p> <p>10 MR. ORENT: Objection.</p> <p>11 THE WITNESS: That's not correct</p> <p>12 statement. I can find features which will give me</p> <p>13 indication what was shape in vivo. I am able to</p> <p>14 say what was shape in vivo.</p> <p>15 BY MS. BYARD:</p> <p>16 Q. Let's take that up in a little</p> <p>17 bit, if you don't mind.</p> <p>18 Returning, though, to your statement</p> <p>19 that the heat-treated edges don't curl, was that</p> <p>20 your basic observation?</p> <p>21 A. Generally, yes.</p> <p>22 Q. Okay. And so the de-tanged</p> <p>23 sub-urethral portion of the Boston Scientific mesh</p> <p>24 slings had a lesser propensity to curl?</p> <p>25 A. That's correct.</p>
<p style="text-align: right;">Page 19</p> <p>1 to say that. And these factors, the efficacy, it</p> <p>2 was a clinical question that had to be a long-term</p> <p>3 clinical study.</p> <p>4 BY MS. BYARD:</p> <p>5 Q. Okay. What were the -- you said</p> <p>6 there are some differences. What were the tissue</p> <p>7 responses that you've seen that are different</p> <p>8 between tanged and de-tanged mesh?</p> <p>9 A. If it's tanged, the edges don't</p> <p>10 curl as much. So if it's a sling, I can see</p> <p>11 clearer difference. When it gets excised, the</p> <p>12 heat-treated portion doesn't curl. But then there</p> <p>13 is a sharp transition into non-heat-treated</p> <p>14 portions, and they curl.</p> <p>15 So if those slings were not -- I mean,</p> <p>16 original slings were not heat-treated, so the whole</p> <p>17 length is curled into a rope. But if there is</p> <p>18 section is treated, that section doesn't curl, but</p> <p>19 the ends curl. So I can see the difference. But</p> <p>20 the design failed in one way or another.</p> <p>21 Q. And so a distinction I might try</p> <p>22 and make throughout the day, and I want to make</p> <p>23 sure it's accurate. You're talking about the shape</p> <p>24 of the mesh itself, right, if it curls --</p> <p>25 A. Shape before insertion, or shape</p>	<p style="text-align: right;">Page 21</p> <p>1 MR. ORENT: Objection.</p> <p>2 BY MS. BYARD:</p> <p>3 Q. In terms of the tissue response,</p> <p>4 the amount of inflammation that you've seen was the</p> <p>5 same between de-tanged and non-de-tanged mesh,</p> <p>6 though?</p> <p>7 A. It's exactly the same. There is</p> <p>8 no difference. No detectable difference.</p> <p>9 Q. And you make a distinction between</p> <p>10 an inflammatory response that you see under a</p> <p>11 microscope and a foreign body reaction; correct?</p> <p>12 A. A foreign body reaction is an</p> <p>13 inflammatory response. I don't make a distinction.</p> <p>14 Q. Okay.</p> <p>15 A. I make distinction between types</p> <p>16 of inflammatory reaction.</p> <p>17 Q. In particular, whether or not</p> <p>18 there is a presence of multinucleated cells or</p> <p>19 giant cells?</p> <p>20 A. These are just microfibers who</p> <p>21 decided to become multinucleated. So there is no</p> <p>22 difference between multinucleated microphage and</p> <p>23 single nucleated microphage. Functionally,</p> <p>24 genetically, they're all the same.</p> <p>25 Q. Does it tell you whether or not</p>

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<p>1 the inflammatory reaction is in response to a 2 foreign body, though, depending on the type of 3 macrophage? 4 A. No. All macrophage is a reaction 5 to foreign body. 6 Q. Okay. 7 A. If there is a foreign body, and 8 there are macrophages, they're reacting. Because, 9 generally, the foreign body or granulomatous 10 reaction is defined as epithelioid histiocytes or 11 macrophages. 12 Q. So if my question were whether you 13 had seen any difference in the foreign body 14 reaction between de-tanged and tanged meshes, your 15 answer would be the same; wouldn't it? No, you 16 didn't see a difference? 17 MR. ORENT: Objection. Asked and 18 answered. 19 THE WITNESS: That's correct. I did 20 not see the difference. 21 BY MS. BYARD: 22 Q. Okay. I want to look at your 23 billing records once we have copies of them, but do 24 you have a number in mind of all told how much 25 you've been paid by Plaintiffs in the mesh</p>	<p>1 complete the billing. 2 BY MS. BYARD: 3 Q. But you will by the time you file 4 your taxes? 5 A. Yes. 6 Q. And when do you anticipate doing 7 that? 8 A. Next spring. 9 Q. Did you do anything to prepare for 10 your deposition today? 11 A. I prepared documents for you on 12 the flash drive. 13 Q. Did you meet with counsel to 14 review documents? 15 A. Yes, we met yesterday. 16 Q. Have you prepared by phone for 17 your deposition here today? 18 A. No. 19 Q. How long did you meet yesterday? 20 A. A couple of hours. 21 Q. And did you review any materials 22 that weren't provided on that flash drive? 23 A. No, we just went through whatever 24 was on the flash drive and my reports. 25 Q. Do you intend to bill for the time</p>
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<p>1 litigation for your expert work against Boston 2 Scientific? 3 A. It's hard to say now, because I 4 don't keep that exact records, really, I'm so busy. 5 Last year my income tax return was 6 \$24,000 from depositions and statements. This year 7 it's larger. I don't know how much larger. 8 Q. Is it two times larger? 9 MR. ORENT: Objection. 10 THE WITNESS: Possibly. 11 BY MS. BYARD: 12 Q. Could it be three times larger? 13 MR. ORENT: Objection. 14 THE WITNESS: I don't want to guess. 15 BY MS. BYARD: 16 Q. What would you need to do to 17 calculate for me how much money you've been paid by 18 plaintiffs for acting as an expert against mesh 19 manufacturers? 20 A. I would have to -- 21 MR. ORENT: Objection. Form. 22 THE WITNESS: I would have to complete 23 billing, which I have not completed yet. I mean, 24 this is a long list, it takes a long time to 25 produce all of this, and I just didn't have time to</p>	<p>1 that you spent yesterday with counsel? 2 A. Yes. 3 Q. How much is your rate now? 4 A. 475. 5 Q. It's gone up. 6 A. I published, so I don't think it's 7 too high. I mean, I see some reports which are 8 much higher. 9 Q. So you hadn't worked on mesh 10 before as a subject area or a material before 2013, 11 right? 12 A. 2012. 13 Q. 2012? 14 A. Yeah, first time I saw it -- 15 became involved in this was end of 2012. 16 Q. And that was your work with 17 Dr. Bendavid on hernia meshes; correct? 18 A. That's correct. 19 Q. And then in 2013 you were 20 approached by Plaintiffs' attorneys in litigation 21 and began working on transvaginal mesh as opposed 22 to hernia mesh; correct? 23 MR. ORENT: Objection. 24 THE WITNESS: I don't know who 25 approached me first. So I don't remember now what</p>

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<p>1 was my first transvaginal specimen. Probably an 2 attorney, probably Dr. Thomson asked me to look at 3 it. Maybe, maybe not. I don't know, I don't 4 remember now.</p> <p>5 BY MS. BYARD: 6 Q. Okay. And originally your rate 7 was \$400, and now it's \$475, right? 8 A. That's correct. 9 Q. And why did you increase your 10 rate? 11 A. As I said, I published, I'm more 12 experienced. It wouldn't be unfair, because when I 13 started I had no experience in litigation cases. 14 Q. So since beginning work on 15 transvaginal mesh matters in 2013, and now sitting 16 here today at the end of 2014, you've now published 17 articles on the subjects of this litigation; correct? 18 A. No, this is not correct. I didn't 19 publish on the subject of litigation. I published 20 on my research, on topics of surgical polypropylene 21 meshes. 22 Q. Based on your review of specimens 23 provided to you by Plaintiffs' attorneys in 24 litigation? 25 MR. ORENT: Objection.</p>	<p>1 You recognize it, though? 2 A. Yes, this is my document. 3 Q. And if you flip into the document, 4 you'll see your signature on it? Hopefully. 5 MR. ORENT: Page 65. 6 THE WITNESS: Yes, I do. 7 BY MS. BYARD: 8 Q. What date did you sign this report? 9 A. November 10th. 10 Q. When did you start working on it? 11 A. This is a general report, so 12 essentially, this has been transformed original 13 report. We discussed in January, so it just was 14 modified several times, reformatted and new images 15 were inserted so... 16 If you ask me when I started working on 17 this, it would be probably two thousand and -- 18 early -- late 2013. 19 Q. Okay. Have you issued similar 20 reports, reports in formatting similar to this one 21 in the other mesh manufacturers' cases? 22 A. Yes. Usually we keep the same 23 format, general report and case-specific reports. 24 Q. Visually, this report appears 25 different than the report I originally deposed you</p>
Page 27	Page 29
<p>1 THE WITNESS: Most publications 2 actually are based on hernia meshes, which were 3 coming from just regular patients. I examined more 4 specimens for litigation, but publications are 5 mostly based on that. 6 BY MS. BYARD: 7 Q. Okay. We can take a look at those 8 articles. Before we do, though, let's mark your 9 report as 1196. 10 MS. BYARD: Do you need a copy, John? 11 MR. ORENT: Yeah, we'll take copies of 12 everything, just position them on my list here 13 somewhere. 14 EXHIBIT NO. 1196: General Expert 15 Report of Dr. Vladimir Iakovlev dated 16 November 10, 2014. 17 BY MS. BYARD: 18 Q. Doctor, do you recognize 1196? 19 A. Strange, 1196. Where are 1195? 20 Q. Sorry, that's just the exhibit 21 number. Do you recognize this document? 22 A. Yes, I do recognize this. It's 23 just, exhibit usually starts with number one, but 24 now it's throwing me. 25 Q. I know, I know. You and me both.</p>	<p>1 about in January of 2014. Do you agree with me 2 about that? 3 A. Yes. This is more structured. 4 Because I understood that, medically, though 5 moderate, a little bit difference, so it's not a 6 guide for -- my report shouldn't be a guide for a 7 clinician. It should be more of a legal document. 8 Q. And I understand that you've 9 continually built on your base knowledge in coming 10 at what we have here as a final work product. But 11 when was the transition made between the format of 12 a report that we looked at in January of 2014 to 13 what we see here today? 14 MR. ORENT: Objection. 15 THE WITNESS: In October or November. 16 Because some of the supplied reports, they had 17 older general part, older format. And some had -- 18 so it was somewhere in -- during my work on this 19 report. I had to streamline it. This is a huge 20 number, a huge amount of work. I had to streamline 21 it and kind of organize it in a way that it would 22 be easier to produce this large number. 23 BY MS. BYARD: 24 Q. And that was one of my questions 25 for you. I don't want to get into the</p>

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<p>1 case-specific reports today, but some of them 2 revert to the earlier format that you used, right? 3 A. Yes. 4 Q. But the exhibit that we're looking 5 at, 1196, this reflects the most -- I guess your 6 most distilled version of your opinions in this 7 litigation; is that fair? 8 A. I don't know about distilled, but 9 it's most updated version, most recent. 10 Q. So if we wanted to talk about your 11 current opinions, it would be better for us to work 12 off of 1196 than the version that I deposed you 13 about in January of 2014, right? 14 A. Yes, it would be easier. 15 Q. Okay. Notwithstanding the fact 16 that that older version appears inserted in some of 17 these case-specific reports that we'll talk about 18 tomorrow, right? 19 A. That's correct. 20 Q. Okay, good. Turning to your 21 report, we start off with your qualifications. Are 22 you with me? 23 A. Yes, I am. 24 Q. Have there been -- and then we 25 have attached as an exhibit to your report, we have</p>	<p>1 testing in a laboratory environment." 2 Did I read that correctly? 3 A. Yes, that's correct. 4 Q. I believe we previously 5 established, but I wanted to make sure in light of 6 this language, that you haven't reviewed any of 7 Boston Scientific's internal testing? 8 A. No, not specifically Boston 9 Scientific. 10 Q. Okay. And have you reviewed any 11 of Boston Scientific's biocompatibility testing? 12 A. No, not internally. 13 Q. Have you reviewed any of Boston 14 Scientific's animal testing? 15 A. As I said, I had no access to 16 specifically internal documents of Boston Scientific. 17 Q. Would it interest you, as a 18 pathologist, to see what Boston Scientific's animal 19 testing revealed about the tissue response to its 20 products? 21 A. Yes, it would be interesting. 22 Q. Is that anything that you 23 requested from the Plaintiffs' counsel? 24 MR. ORENT: Objection. 25 THE WITNESS: It didn't occur to me</p>
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<p>1 your CV; true? 2 A. Yes, I saw it. 3 Q. I think it's Exhibit A. 4 Apart from the publications that I'll 5 talk about here in a moment as they come up in the 6 report, have there been any other updates to your 7 CV or your qualifications? 8 A. Publications, presentations, 9 abstracts, posters, that's main things, nothing 10 else. 11 Q. Okay. 12 A. I'm still working in the same place. 13 Q. Same place, same title? 14 A. (Witness nods.) 15 Q. Very good. And if we go further 16 into your report, you have a section -- it's the 17 second paragraph on page 2. It's the first full 18 paragraph. 19 Here where you're talking about the 20 research that you started with Dr. Bendavid, you 21 mention in the last sentence that: 22 "Previous studies in 23 manufacturers' testing have been 24 concentrated on experimental 25 modeling in animals and controlled</p>	<p>1 that you would provide it. 2 BY MS. BYARD: 3 Q. And similarly, you haven't done a 4 review of the literature for clinical studies 5 conducted on Boston Scientific's products, right? 6 MR. ORENT: Objection. 7 THE WITNESS: Repeat -- 8 MR. ORENT: Hold on one second. 9 Do you mean "randomized control"? 10 Because the term "study" has a very specific 11 meaning in science. 12 MS. BYARD: Counsel, please don't coach 13 the witness with your objections. 14 MR. ORENT: No. I'm asking you to 15 clarify the question. 16 BY MS. BYARD: 17 Q. Clinical studies, studies in 18 humans. 19 What does "clinical studies" mean to 20 you, sir? 21 A. Please repeat the first question. 22 Q. Sure. What does clinical -- what 23 does the term -- 24 A. No, no, previous question. 25 Q. No, that's okay. It's my</p>

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<p>1 deposition. What is --</p> <p>2 MR. ORENT: Are you withdrawing the</p> <p>3 prior question?</p> <p>4 MS. BYARD: Yes, I'll withdraw that.</p> <p>5 BY MS. BYARD:</p> <p>6 Q. What does the term "clinical</p> <p>7 studies" mean to you as opposed to "preclinical</p> <p>8 studies"?</p> <p>9 A. Clinical studies, when it's</p> <p>10 experimental testing is done on patients.</p> <p>11 Q. Okay. Have you reviewed any of</p> <p>12 the clinical studies, so testing on humans, of</p> <p>13 Boston Scientific's products?</p> <p>14 MR. ORENT: Objection.</p> <p>15 THE WITNESS: I have reviewed published</p> <p>16 literature from clinical studies, including Boston</p> <p>17 Scientific. Usually it's a mix, it's not a</p> <p>18 separate -- sometimes it's a separate device, but</p> <p>19 mostly it's a mix.</p> <p>20 BY MS. BYARD:</p> <p>21 Q. Okay. So you couldn't say, you</p> <p>22 couldn't sit here today and testify that you've</p> <p>23 reviewed all 25-plus Obtryx studies, for instance;</p> <p>24 could you?</p> <p>25 MR. ORENT: Objection. Foundation.</p>	<p>1 Q. Okay.</p> <p>2 A. I have piles sitting on my desk</p> <p>3 now to sort out, maybe Christmastime.</p> <p>4 Q. Okay. And so when was the last</p> <p>5 time you updated this spreadsheet?</p> <p>6 A. Late August, early September,</p> <p>7 somewhere in that time. It was slow time, so I</p> <p>8 could, could do that.</p> <p>9 MR. ORENT: Vladimir, can you just keep</p> <p>10 your voice up.</p> <p>11 THE WITNESS: Sure, yeah. Just remind</p> <p>12 me.</p> <p>13 BY MS. BYARD:</p> <p>14 Q. I don't know that we have a copy</p> <p>15 of the spreadsheet, so that's something that I</p> <p>16 would request.</p> <p>17 A. I provided it in July. I don't</p> <p>18 remember if I updated since then, but it could be a</p> <p>19 small update.</p> <p>20 Q. Okay.</p> <p>21 A. But you received a copy in July.</p> <p>22 I think in July it was 97 transvaginal cases.</p> <p>23 Q. So I don't, though, have a</p> <p>24 spreadsheet that would reflect this 120 number of</p> <p>25 samples that appears here in your report, right?</p>
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<p>1 I think the record speaks to the fact</p> <p>2 there aren't 25 studies in Obtryx.</p> <p>3 MS. BYARD: Counsel, please, make a</p> <p>4 form objection.</p> <p>5 THE WITNESS: I have a large hard drive</p> <p>6 filled with publications which I reviewed. I don't</p> <p>7 remember how many of those were Obtryx and so --</p> <p>8 but I can tell you that I read a lot of clinical</p> <p>9 studies.</p> <p>10 BY MS. BYARD:</p> <p>11 Q. Okay. I want to turn to the next</p> <p>12 paragraph here in this preface to your report,</p> <p>13 which talks about your review of polypropylene mesh</p> <p>14 explants. Are you with me?</p> <p>15 A. Yes.</p> <p>16 Q. And you reference, "now having</p> <p>17 approximately 120 samples being transvaginal mesh</p> <p>18 explants."</p> <p>19 A. This number is probably higher</p> <p>20 now, something like 150.</p> <p>21 Q. Is there a way that you track this</p> <p>22 number?</p> <p>23 A. When I have time, I sit and then</p> <p>24 start putting them in spreadsheet. But I haven't</p> <p>25 done it for last two months.</p>	<p>1 A. I'm not sure if it exists. And,</p> <p>2 yes, I counted those 97. I know the number because</p> <p>3 I could count them quickly, but they are not</p> <p>4 entered in the spreadsheet.</p> <p>5 Q. Okay. I guess I should back up</p> <p>6 for a second.</p> <p>7 Are you fully prepared to discuss all</p> <p>8 the opinions that are set forth in your report</p> <p>9 today?</p> <p>10 A. Yes.</p> <p>11 Q. Okay. And have you seen</p> <p>12 everything that you need to see, to offer the</p> <p>13 opinions that are set forth here in 1196?</p> <p>14 A. Yes.</p> <p>15 Q. Okay. And do you have any</p> <p>16 additional info, information, at this time that</p> <p>17 would change the opinions that are reflected here</p> <p>18 in Exhibit 1196?</p> <p>19 A. No.</p> <p>20 Q. Okay. And did your report include</p> <p>21 all of the opinions, the basis and the reasons for</p> <p>22 your opinions that you intend to offer in trial on</p> <p>23 these matters?</p> <p>24 A. No. Because basis of my opinions</p> <p>25 is my career, my knowledge and everything. It</p>

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<p>1 cannot fit in this report. It's just a summary. 2 Q. Are all of the opinions that you 3 intend to offer at trial set forth in this report, 4 Exhibit 1196? 5 A. As I said, there's a summary, yes. 6 Q. And you understand that if there 7 are updates to this information, that you'll 8 supplement this through counsel, right? 9 MR. ORENT: Objection. 10 THE WITNESS: That's correct. 11 BY MS. BYARD: 12 Q. Of these 120 samples that -- of 13 transvaginal mesh that you had at least as of the 14 date that you authored your report and signed it, 15 how many of those had come to you through 16 Plaintiffs' attorneys? 17 A. Ratio is somewhat close to 18 70 percent. Again, it's approximate ratio. 19 Q. Previously when we've deposed you, 20 you've testified that you didn't know how the 21 Plaintiffs' attorneys selected the specimens that 22 they sent to you; do you recall that? 23 A. I don't know the specific details, 24 but I think it's an irrelevant question, because 25 nobody knows what's in the specimen unless you look</p>	<p>1 BY MS. BYARD: 2 Q. Okay. I'd like to look with you, 3 and I'll represent to you that these are reports 4 that my expert, Dr. Steven Badylak, put together 5 based on specimens that he reviewed. 6 And the first is for a woman named 7 Ellen Hoffman; another is for a woman named Connie 8 Bennett; and another is for a woman named Deborah 9 Kilgore. If you wouldn't mind taking the time to 10 just briefly review those. 11 MR. ORENT: Let me see those. 12 THE WITNESS: They look awfully short 13 in comparison to mine. 14 MS. BYARD: There was no question 15 pending, sir. 16 MR. ORENT: I have multiple objections 17 to the use of these documents by Dr. Iakovlev. 18 Particularly, one, to the extent that 19 this contains information that may relate to the 20 private healthcare information of individuals who 21 Dr. Iakovlev has not intended to offer any specific 22 testimonies on. 23 So to the extent that this relates to 24 any protected healthcare information under HIPAA, 25 I'm going to place an objection on the record to</p>
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<p>1 in the microscope. So they selected it blindly. 2 MS. BYARD: Object and move to strike. 3 BY MS. BYARD: 4 Q. Do you recall having testified 5 before that you didn't know how the Plaintiffs' 6 attorneys selected the specimens that they sent to 7 you? 8 MR. ORENT: Wait a minute. Hold on. 9 He's entitled to a full answer, so we 10 would oppose any motion to strike. 11 Go ahead and answer to the extent that 12 you need to, to make sure that you're offering a 13 full testimony, full response to the question. 14 BY MS. BYARD: 15 Q. My question is whether you 16 testified before that you didn't know how 17 Plaintiffs' attorneys selected the specimens that 18 they gave to you? 19 MR. ORENT: Objection. 20 THE WITNESS: What was their 21 methodology? I don't know. 22 But as I said, they selected it blindly 23 because they couldn't see what's in the specimen. 24 There's no way of seeing -- I don't know what I'm 25 going to find in a specimen before I cross it.</p>	<p>1 that. 2 Second, to the extent that it goes 3 beyond the scope of any of his opinions, I would 4 object to that. 5 And, I object to asking him to form new 6 opinions on the basis of something that he's never 7 seen before today. 8 And third, I'm not sure -- we have 9 multiple questions. These are very new reports, 10 and I'm not sure where the specimens originated 11 from in all of these cases. So subject to those 12 objections -- 13 MS. BYARD: Has he signed a protective 14 order? 15 MR. ORENT: He has not. 16 MS. BYARD: And so how would his review 17 of these specimens be any different from the 18 protected health information that you provide to 19 him in the form of samples of human tissue? 20 MR. ORENT: He's retained as an expert 21 and as a treating -- as a physician, he's subject 22 to the code of medical ethics. 23 MS. BYARD: Okay. 24 BY MS. BYARD: 25 Q. Let me just ask you, Doctor, have</p>

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<p>1 you reviewed a pathological specimen for Ellen 2 Hoffman?</p> <p>3 MR. ORENT: And I'm also going to 4 object, because that is -- to the extent that 5 you're asking questions whether or not he's been a 6 disclosed or undisclosed expert, he doesn't need to 7 answer that question under Rule 26.</p> <p>8 So I'm going to instruct you not to 9 answer.</p> <p>10 BY MS. BYARD: 11 Q. Are you going to follow Counsel's 12 instruction?</p> <p>13 A. Yes.</p> <p>14 Q. Have you reviewed a specimen for 15 Deborah Kilgore?</p> <p>16 MR. ORENT: I need to consult with the 17 witness on this.</p> <p>18 MS. BYARD: Okay. We can go off the 19 record.</p> <p>20 THE VIDEOGRAPHER: Off the record at 21 9:50 a.m.</p> <p>22 -- RECESS AT 9:50 -- 23 -- UPON RESUMING AT 9:59 --</p> <p>24 THE VIDEOGRAPHER: One moment, please. 25 We're back on the record at 9:59 a.m.</p>	<p>1 MR. ORENT: And I also --</p> <p>2 MS. BYARD: And you can instruct him as 3 you think prudent.</p> <p>4 MR. ORENT: Okay. Just to be clear. 5 By allowing us, allowing Dr. Iakovlev to answer 6 questions as to his recollection about these 7 particular samples, we're not waiving anything in 8 terms of privileges, regarding communications or 9 anything else in those cases, or generally 10 speaking.</p> <p>11 BY MS. BYARD: 12 Q. Let's return to my question then, 13 Doctor, on Ellen Hoffman.</p> <p>14 Did you review her pathology specimens? 15 A. I would have to check. (Witness 16 reviews documents.)</p> <p>17 Okay. She is not on this list. There 18 is "Hoffman, Lori," but she is not on the list.</p> <p>19 Q. Okay. So -- 20 A. But -- 21 Q. You know you didn't issue a report 22 on Ellen Hoffman?</p> <p>23 MR. ORENT: Objection. 24 THE WITNESS: I don't recall. But 25 again, I don't remember now.</p>
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<p>1 MR. ORENT: So, Counsel, and I have 2 spoken off the record, and I've spoken with 3 Dr. Iakovlev.</p> <p>4 The issue that is concerning 5 Plaintiffs' counsel for the MDL, is that there is 6 the chance that we are moving from areas where 7 Dr. Iakovlev has been disclosed as a testifying 8 expert to areas where he may have been retained by 9 individual case counsel in a consulting capacity.</p> <p>10 First and foremost, Plaintiffs want to 11 ensure that there's not going to be a waiver by 12 allowing Dr. Iakovlev to testify to certain factual 13 findings that he had. And consistent with that, we 14 will allow him to testify to the factual nature of 15 things that he saw, or didn't see.</p> <p>16 However, we would -- we will object to 17 any questions relating to his interactions with 18 counsel, his interactions with counsel in terms of 19 writing a report, or not writing a report, and the 20 decision to file or not file a report in a 21 particular case.</p> <p>22 MS. BYARD: So what I'd like to do is, 23 I'll ask my questions along the lines that you've 24 just outlined. I will ask some questions to make a 25 record in case I need it later.</p>	<p>1 BY MS. BYARD: 2 Q. And you can't tell me whether or 3 not you reviewed her pathology or not --</p> <p>4 A. If I -- 5 Q. -- sitting here today? 6 A. If I didn't issue a report, I 7 didn't review it.</p> <p>8 Q. Okay. 9 A. Again, I mean, she's not on the 10 list, so I don't recall now.</p> <p>11 Q. Okay. Do you know whether or not 12 there were cases where you formulated reports which 13 were never disclosed to me?</p> <p>14 MR. ORENT: Objection. 15 On that one, I'm going to instruct the 16 witness not to answer.</p> <p>17 THE WITNESS: You're instructing not to 18 answer?</p> <p>19 MR. ORENT: Yes. 20 THE WITNESS: Okay. 21 BY MS. BYARD: 22 Q. Are you aware of any instances 23 when you've written reports on cases which were 24 never ultimately provided?</p> <p>25 MR. ORENT: Again, I'm going to</p>

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<p>1 instruct the witness not to answer.</p> <p>2 BY MS. BYARD:</p> <p>3 Q. Do you know if there are instances</p> <p>4 when counsel had pathological specimens that were</p> <p>5 never provided to you?</p> <p>6 A. How would I know that?</p> <p>7 Q. And returning to Deborah Kilgore,</p> <p>8 did you review pathology for her?</p> <p>9 MR. ORENT: Again, subject to my prior</p> <p>10 objections.</p> <p>11 THE WITNESS: She's not on the list.</p> <p>12 BY MS. BYARD:</p> <p>13 Q. And the list that you're referring</p> <p>14 to, is a list of cases where you have reports that</p> <p>15 have been noticed for the deposition, right?</p> <p>16 A. Yes. And there are a few more,</p> <p>17 which are not on the list. But I may not recall</p> <p>18 it. I mean, there is a huge number, like there is</p> <p>19 30. How can I remember all these names?</p> <p>20 Q. Okay. You're not looking at a</p> <p>21 chain of custody for specimens that have been</p> <p>22 received by your lab, from Steelgate, are you?</p> <p>23 A. No, we're not looking at that. I</p> <p>24 could have received some -- sometimes specimens</p> <p>25 come dry, and I cannot examine it. Or there is a</p>	<p>1 A. Ask the question again.</p> <p>2 Q. You'll acknowledge, though, won't</p> <p>3 you, that women have excisions following pelvic</p> <p>4 surgery, resulting in specimens that don't even</p> <p>5 contain mesh?</p> <p>6 A. Yes. There are some specimens</p> <p>7 which don't contain mesh.</p> <p>8 Q. Those were surgeries performed</p> <p>9 because women were experiencing complications,</p> <p>10 right?</p> <p>11 MR. ORENT: Objection.</p> <p>12 THE WITNESS: Specimens I received</p> <p>13 don't have mesh. But I don't know if they had mesh</p> <p>14 while they were processed in the original</p> <p>15 institution.</p> <p>16 So what happens, original institution</p> <p>17 shaves off subtissue, puts it in the block, and the</p> <p>18 mesh is discarded.</p> <p>19 So if it was original excised, and I</p> <p>20 didn't receive it, or it wasn't excised, this, this</p> <p>21 sometimes is a difficult question.</p> <p>22 BY MS. BYARD:</p> <p>23 Q. And you don't even know if the</p> <p>24 original institution shaved off the tissue or</p> <p>25 whether there was even mesh to begin with; correct?</p>
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<p>1 piece of suture or calcification, something like</p> <p>2 this. I mean...</p> <p>3 Q. Okay.</p> <p>4 A. Or in some cases, it's not mesh,</p> <p>5 it's like a uterus or...</p> <p>6 I think even for uterus, I issued a</p> <p>7 report but...</p> <p>8 Q. So in some of the pathological</p> <p>9 specimens that you've received, there isn't even</p> <p>10 any mesh, right?</p> <p>11 A. In some specimen, yeah, I receive</p> <p>12 sometimes just a -- it's mucosa, or scar tissue</p> <p>13 with some changes adjacent to the mesh, sometimes</p> <p>14 just mucosa.</p> <p>15 Q. In those instances, you don't</p> <p>16 issue a report, do you?</p> <p>17 MR. ORENT: Objection.</p> <p>18 THE WITNESS: It depends. If I see --</p> <p>19 MR. ORENT: I'm going to instruct the</p> <p>20 witness not to answer this particular question.</p> <p>21 BY MS. BYARD:</p> <p>22 Q. You'll acknowledge, though, won't</p> <p>23 you, that women have excisions following pelvic</p> <p>24 surgery resulting in specimens that don't include</p> <p>25 mesh; correct?</p>	<p>1 A. In some cases it's described in</p> <p>2 the pathology report, that they describe mesh; but</p> <p>3 they didn't submit sections.</p> <p>4 Q. And in other --</p> <p>5 A. If I have a pathology report.</p> <p>6 Sometimes I don't have a pathology report.</p> <p>7 Q. Now, they use 120 samples that you</p> <p>8 speak of in your report. Do those include</p> <p>9 specimens that you received where you never</p> <p>10 ultimately issued a report?</p> <p>11 A. Which report? That's a question,</p> <p>12 surgical pathology report, report which is served?</p> <p>13 Q. Either one.</p> <p>14 A. No. I enter only those cases I</p> <p>15 examine in one way or another and -- actually,</p> <p>16 those 120 samples, they had mesh. So I could find</p> <p>17 features specific for the mesh. Either mesh or</p> <p>18 features specific for the mesh.</p> <p>19 Q. So these 120 exclude cases where</p> <p>20 there were no findings related to mesh?</p> <p>21 A. No.</p> <p>22 MR. ORENT: Objection.</p> <p>23 BY MS. BYARD:</p> <p>24 Q. Right?</p> <p>25 A. That's not correct.</p>

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<p>1 So the specimen contains a mesh, and 2 it's from vaginal area, then I examine it. If it's 3 specimen -- sometimes, as I said, I receive a 4 uterus. So why would I include the uterus -- 5 findings of a uterus in a spreadsheet which is 6 research -- which is made for research purposes for 7 mesh. 8 So I examined those, I issue report for 9 uterus, but then they don't use it for this 10 purpose, research purpose. So it's not listed 11 there. Or sometimes I receive three, four 12 specimens for the same patient. Some of them have 13 sort of piecemeal excision at the same time, or 14 excisions are spread during time. 15 Q. So for any specimen that you 16 receive, provided there is mesh, you issue a 17 pathology report? 18 A. Sooner or later, I -- any specimen 19 which came in and had to be registered at 20 St. Michael's Hospital, I issue surgical pathology 21 report. 22 Q. And does that include the 23 specimens that you receive through Plaintiff's 24 counsel? 25 A. Yes. It doesn't matter if it</p>	<p>1 Assuming if I receive three, four 2 specimens for the same patient, I get three, four 3 different surgical pathology cases. Or, if two 4 specimens were excised on the same day, they can be 5 accessioned as one surgical number with A and B. It 6 depends on the patient. Sometimes it's 1 and 2, 7 A and B. 8 So, are you counting number of cases, 9 or are you counting number of patients, or are you 10 counting number of meshes? Some patients have 11 three meshes. 12 Q. How do you log it? 13 A. We log by surgical number in 14 St. Michael's Hospital. So if a specimen comes as 15 a one, on one single requisition, marked A and B, 16 it becomes one surgical number. Specimen A and 17 specimen B. But sometimes I receive them spread in 18 time, and then the accessioning becomes spread in 19 time, so there are two surgical numbers. 20 Or, if I can catch it, when I receive 21 it, then I can put it on the same number, just add 22 it. Again, it's not straightforward sometimes. 23 Q. Okay. We don't have in your 24 report the number of specimens that you've received 25 by surgical number, do we?</p>
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<p>1 contains a mesh or doesn't contain a mesh, surgical 2 pathology report needs to be issued. I have to 3 sign it out as a diagnostic pathologist, and have 4 to produce surgical pathology report. 5 Q. So irrespective of whether counsel 6 ultimately disclosed a report for you in a case, 7 you would have logged it when that specimen came in 8 to you at St. Michael's; true? 9 MR. ORENT: Objection. 10 THE WITNESS: That's true. I cannot do 11 staining or I cannot do anything without logging it in. 12 BY MS. BYARD: 13 Q. Okay. And so the 120 number would 14 be your number of what -- the number of specimens 15 that you had received? 16 A. 120 -- 17 MR. ORENT: Objection. 18 THE WITNESS: 120 is mesh specimens. 19 Those specimens I extracted knowledge about mesh 20 body interactions. 120 is not a log number. 21 BY MS. BYARD: 22 Q. Do you have a log number? 23 A. It's in St. Michael's information 24 system. And cases are accessioned and they are 25 there.</p>	<p>1 MR. ORENT: Objection. 2 THE WITNESS: No. I haven't logged 3 them, those. 4 BY MS. BYARD: 5 Q. St. Michael's did, though, didn't 6 they? 7 A. I mean, well, they don't count 8 number of specimens received. I can try to do 9 search by words, like "vaginal mesh" or something 10 like this. But sometimes they come without 11 definition of mesh, so accessioning clerk doesn't 12 know that it's mesh, and it's just entered as 13 "tissue." So this would escape search by word. 14 Q. So today, there's no way for us to 15 recreate however many specimens you've received 16 through the mesh litigation? 17 A. Exact up to single specimen? No, 18 this would be difficult. 19 There is no -- I mean, in ballpark, 20 yes. But, I mean, specifically trace each single 21 specimen would be hard. Probably chain of custody 22 forms, this would be easier. But then they are 23 spread all over, I mean, from different sources. 24 Q. Do you have copies of all the 25 chain of custody forms that you've received, the</p>

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<p>1 specimens you've received through the mesh 2 litigation?</p> <p>3 A. Yes, I do keep copies. But 4 sometimes chain of custody forms comes in, and then 5 there are three specimens behind it. They put on 6 one chain of custody forms, and then next patient 7 has three different specimens, which are coming 8 from three different sources with three different 9 chains of custody.</p> <p>10 And sometimes chain of custody doesn't 11 specify how many specimens, which shape they came 12 in. I describe them in surgical pathology report 13 each time I describe the specimen.</p> <p>14 Q. Okay. So returning to specimens 15 where you either haven't reviewed or haven't issued 16 a report that we know of, this Connie Bennett case 17 that I mentioned before; is that one that's 18 familiar to you?</p> <p>19 MR. ORENT: Subject to my same 20 objections.</p> <p>21 THE WITNESS: As I said, it's not a 22 memory test. I cannot remember.</p> <p>23 I don't remember the name. I may or 24 may not have -- is it on the list? 25</p>	<p>1 BY MS. BYARD: 2 Q. In short, you can't assure to me 3 that all of the specimens that are available 4 through counsel, had been provided to you, can you?</p> <p>5 A. How can I? I mean, I ask for 6 everything available. Every time there is a new 7 specimens, or a new set of specimens coming out, 8 I'm asking for all available medical records and 9 all available specimens.</p> <p>10 Q. Beyond that, you can't assure, 11 though, that your request has been fulfilled?</p> <p>12 MR. ORENT: Objection.</p> <p>13 BY MS. BYARD: 14 Q. Can you?</p> <p>15 A. No.</p> <p>16 Q. Similarly, you can't assure me 17 that every specimen that you've examined has 18 resulted in a report that's been provided to me, 19 can you?</p> <p>20 MR. ORENT: I'm instructing you not to 21 answer.</p> <p>22 BY MS. BYARD: 23 Q. Okay. Let's continue with this 24 paragraph that we're looking at, if you don't mind, 25 Doctor. It says:</p>
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<p>1 BY MS. BYARD: 2 Q. And again, you're looking at the 3 list of your reports?</p> <p>4 A. Yes. What was the last name?</p> <p>5 Q. Connie Bennett, B-E-N-N-E-T-T?</p> <p>6 A. (Witness reviews document.) 7 It's not on this list. I could have 8 issued the report, could have. I don't remember 9 now.</p> <p>10 Q. Okay. I'll represent to you, 11 Doctor, that these three cases are cases where my 12 expert has received a specimen and issued a report, 13 okay?</p> <p>14 All I want to know from you, my 15 question is whether you can tell me if you either 16 didn't receive specimens for these women; or, a 17 report that you did on your findings was never 18 provided to me?</p> <p>19 MR. ORENT: I'm going to instruct the 20 witness not to answer those questions.</p> <p>21 THE WITNESS: As per my counsel --</p> <p>22 MS. BYARD: Are you going to follow 23 your counsel? 24 THE WITNESS: I'm going to follow. 25</p>	<p>1 "My data pool of mesh explant 2 samples contains specimens of 3 St. Michael's Hospital patients, 4 cases sent from outside hospitals, 5 as well as potential and active 6 litigation cases sent to me as 7 consultant."</p> <p>8 My only question here is on percentages. 9 And I think you said you thought close to 70 of the 10 120 listed here were cases that came to you through 11 litigation.</p> <p>12 Do you have updated estimates for me of 13 the number of samples that came from St. Michael's 14 Hospital patients and the number sent from other 15 hospitals?</p> <p>16 MR. ORENT: Objection. I just want to 17 clarify. He said 70 percent, not 70.</p> <p>18 BY MS. BYARD: 19 Q. Oh, did you say 70?</p> <p>20 A. Yes, 70 percent.</p> <p>21 Q. Oh, thank you.</p> <p>22 A. Roughly 70 percent, I think. It's 23 an estimate.</p> <p>24 Q. Okay. And then what are the 25 percentages for the others?</p>

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<p>1 A. I mean, 70 from litigation and 30, 2 about 30 non-litigation. 3 Q. So 30 either from St. Michael's or 4 from outside hospitals? 5 A. It's mainly St. Michael's. For 6 transvaginal, it's mainly St. Michael's Hospital. 7 Q. For the outside hospitals, do you 8 know how they select which samples they give to you 9 and which they don't? 10 A. Those clinicians, they just send 11 whatever is available, consecutive. 12 (Reporter sought clarification.) 13 A. Consecutive. 14 Q. But if there are samples that they 15 don't send to you, you wouldn't know about that one 16 way or the other, would you? 17 A. No. 18 MR. ORENT: Objection. 19 BY MS. BYARD: 20 Q. Okay. Turning to the next page, 21 the first full paragraph. 22 And I'm on page 3 of 1196 for the 23 record? 24 A. Yes. 25 Q. You talk about how pathologists</p>	<p>1 of mesh, or more of a raw mesh. 2 (Reporter sought clarification.) 3 A. Raw material, raw material of the 4 mesh. It's not formal device. 5 Q. Is the Prefyx a sling, or is it 6 indicated for the treatment of pelvic organ 7 prolapse? 8 A. Prefyx, I'm not sure about this 9 one. 10 Q. How about the Advantage Fit? 11 A. Advantage is -- I would have to 12 check. I mean, it's not a memory test. Every time 13 I see some name I'm not sure, I just Google and 14 check with Boston Scientific website. 15 Q. Sitting here today, though, you 16 can't tell me? 17 MR. ORENT: Objection. 18 THE WITNESS: I wouldn't guess. I 19 don't want to guess. 20 BY MS. BYARD: 21 Q. What about Uphold? Is that 22 indicated for stress urinary incontinence or for 23 pelvic organ prolapse? 24 A. Pelvic organ prolapse. 25 Q. How many incisions are used to</p>
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<p>1 are trained and develop skills for subjective 2 assessments? 3 A. That's correct. 4 Q. You write that: 5 "To understand the related 6 pathological processes and make a 7 correct diagnosis, pathologists need 8 to understand the function of the 9 devices being analyzed --" 10 A. That's correct. 11 Q. "-- their physical characteristics --" 12 A. That's correct. 13 Q. "-- surgical and other techniques 14 introducing the objects into the body." 15 Right? 16 A. That's correct. 17 Q. Speaking of the devices, is the 18 Solyx a sling or a pelvic organ prolapse device? 19 MR. ORENT: Objection. 20 THE WITNESS: As far as I remember, 21 Solyx is a sling. 22 BY MS. BYARD: 23 Q. Is Polyform indicated for slings 24 or for treatment of pelvic organ prolapse? 25 A. Polyform is just a name of a type</p>	<p>1 place a Solyx? 2 A. It's a clinical question. I'm not 3 a clinician. 4 Q. Where is the incision or incisions 5 located? 6 MR. ORENT: Objection. 7 THE WITNESS: For which type? 8 BY MS. BYARD: 9 Q. Solyx. 10 A. So my understanding is for slings, 11 there is a midline incision, and then there are 12 devices usually trocars used to push the devices 13 further. But the incision is midline to open the 14 area. 15 Q. Does the Obtryx make use of one 16 incision or more than one incision? 17 MR. ORENT: Objection. 18 THE WITNESS: You mean the linear 19 incision or trocar tracks? 20 BY MS. BYARD: 21 Q. Either way. 22 A. Linear incision is one, as far as 23 I understand, in the middle. And then there are 24 trocar tracks. 25 Q. I'm sorry?</p>

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<p>1 A. Which go through skin, so there --</p> <p>2 you need to make an incision in the skin. But then</p> <p>3 it's not an incision linear.</p> <p>4 Q. Where does the -- what you're</p> <p>5 calling the trocar track, or the trocar pass,</p> <p>6 compare in location for an Obtryx versus retropubic</p> <p>7 sling, for instance?</p> <p>8 MR. ORENT: Objection.</p> <p>9 THE WITNESS: A retropubic sling</p> <p>10 doesn't go into a transobturator. So the arms go</p> <p>11 retropubically, pointing upward. So it's --</p> <p>12 BY MS. BYARD:</p> <p>13 Q. Where do the incisions for the</p> <p>14 trocar tracks -- let me start over.</p> <p>15 How do the incisions for the trocar</p> <p>16 tracks or passes for the Obtryx sling compare to</p> <p>17 the Advantage sling?</p> <p>18 MR. ORENT: Objection.</p> <p>19 THE WITNESS: I think we are going</p> <p>20 beyond the scope of what pathologists need to</p> <p>21 understand.</p> <p>22 I need to understand if the sling is</p> <p>23 placed in specific anatomical area, and what</p> <p>24 anatomical spaces are displaced. Specific details</p> <p>25 of surgical techniques need to be understood only</p>	<p>1 Q. So it's your testimony that the</p> <p>2 treatment modalities wouldn't differ depending on</p> <p>3 whether a pudendal nerve branch versus another</p> <p>4 nerve branch were ingrown in mesh?</p> <p>5 A. No.</p> <p>6 MR. ORENT: Objection.</p> <p>7 BY MS. BYARD:</p> <p>8 Q. The reality is that you don't</p> <p>9 treat clinical complications from pelvic mesh, do</p> <p>10 you?</p> <p>11 MR. ORENT: Objection.</p> <p>12 THE WITNESS: No.</p> <p>13 BY MS. BYARD:</p> <p>14 Q. And so you don't need to</p> <p>15 understand, as a pathologist, from your</p> <p>16 perspective, whether or not the nerve that you see</p> <p>17 is a pudendal nerve, or part of an obturator nerve,</p> <p>18 or part of the genital femoral nerves, right?</p> <p>19 A. I think you're misrepresenting.</p> <p>20 You're talking about large nerves, large branches</p> <p>21 so -- which have names. There will be thousands of</p> <p>22 other smaller branches, which don't have names.</p> <p>23 So you're making it kind of like a</p> <p>24 cartoon, more of a -- reality is different. The</p> <p>25 genital area is very richly innervated, nerves</p>
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<p>1 to a degree, which helps me to understand the</p> <p>2 function.</p> <p>3 So you're asking me very specific</p> <p>4 details which would be important for a clinician,</p> <p>5 but as a pathologist, they are not as important to</p> <p>6 me. So, I think we're going beyond what I would</p> <p>7 need to know.</p> <p>8 BY MS. BYARD:</p> <p>9 Q. Well, would the Obtryx device or</p> <p>10 the Uphold device pass closer to the pudendal</p> <p>11 nerve?</p> <p>12 MR. ORENT: Objection.</p> <p>13 THE WITNESS: Obtryx or Uphold. I</p> <p>14 cannot tell you which one would be closer. Again,</p> <p>15 this would be irrelevant, because I see nerve</p> <p>16 ingrowth in both, and it doesn't matter if it's</p> <p>17 coming from a pudendal nerve or any other nerve or</p> <p>18 smaller branch.</p> <p>19 BY MS. BYARD:</p> <p>20 Q. Does it matter for a patient's</p> <p>21 clinical symptomology whether or not there's</p> <p>22 involvement of the pudendal nerve versus other</p> <p>23 nerves?</p> <p>24 A. What matters is involvement of a</p> <p>25 nerve. If it has a name, it doesn't matter.</p>	<p>1 coming from different places. You're talking about</p> <p>2 large nerve, but the branches have no names, and</p> <p>3 then they go in the area. So it's either you have</p> <p>4 a misunderstanding, or just trying to make it look</p> <p>5 like this.</p> <p>6 MS. BYARD: Object and move to strike.</p> <p>7 MR. ORENT: Oppose.</p> <p>8 BY MS. BYARD:</p> <p>9 Q. Does the Uphold fix to any</p> <p>10 specific anatomical structures in the female</p> <p>11 pelvis?</p> <p>12 MR. ORENT: Objection.</p> <p>13 THE WITNESS: What do you mean "fixed"?</p> <p>14 By stitches?</p> <p>15 BY MS. BYARD:</p> <p>16 Q. Sure.</p> <p>17 A. No, there are no stitches.</p> <p>18 Q. Is it affixed to any other</p> <p>19 anatomical landmarks in the pelvis?</p> <p>20 MR. ORENT: Objection. Scope.</p> <p>21 THE WITNESS: I have to ask questions,</p> <p>22 how it is fixed? I mean, is it fixed by stitching,</p> <p>23 or it's fixed by ingrowth?</p> <p>24 BY MS. BYARD:</p> <p>25 Q. Either one.</p>

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<p>1 A. Specifically, the meshes are not 2 stitched to tissues. So they mainly depend on 3 tissue ingrowth. 4 Q. How about fixed by placement to 5 any of the anatomical structures of the pelvis? Do 6 you know whether that occurs? 7 MR. ORENT: Objection. 8 THE WITNESS: What do you mean, "fixed 9 by placement"? 10 Placement is just you place something. 11 BY MS. BYARD: 12 Q. What is the Capiro? 13 A. Pardon? 14 Q. The Capiro? 15 A. I don't know what you're talking about. 16 MR. ORENT: Objection. Scope. 17 BY MS. BYARD: 18 Q. Do Boston Scientific's pelvic mesh 19 products make use of trocars? 20 MR. ORENT: Objection. Vague. Form. 21 Scope. 22 THE WITNESS: What do you mean? 23 BY MS. BYARD: 24 Q. You used the word "trocars" 25 before. What did you mean by that?</p>	<p>1 THE WITNESS: I mean, you're asking me 2 questions which clearly are clinical questions. 3 BY MS. BYARD: 4 Q. Okay. 5 A. As I said, as a pathologist I need 6 to understand what the device looks like, what is 7 it made from, and what anatomical location it is 8 placed, what is its function. 9 That's as much -- that's, basically, 10 generally what I need to know. You're going to 11 somewhere where it's completely beyond my scope, my 12 expertise. 13 Q. You write in your report that you 14 need to understand the function of the devices 15 being analyzed, right? 16 A. Yes. 17 Q. You write that you need to know 18 the devices' physical characteristics, right? 19 MR. ORENT: Objection. These are -- 20 THE WITNESS: The functions for stress 21 urinary incontinence is to support urethra. 22 Physical characteristics, I see it's a 23 polypropylene, it's not biological mesh. That's 24 what I'm talking about. 25</p>
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<p>1 A. It's a device which comes in the 2 kit. It's more of like a long needle. 3 Q. Do Boston Scientific's pelvic 4 organ prolapse kits make use of trocars? 5 MR. ORENT: Objection. 6 THE WITNESS: Yes, they're included in 7 the kits. 8 BY MS. BYARD: 9 Q. Doctor, if I asked you to describe 10 how you perform a Kelly plication, would you be 11 able to do that? 12 MR. ORENT: Objection. Outside the 13 scope. 14 THE WITNESS: I'm a pathologist. I 15 don't do -- 16 BY MS. BYARD: 17 Q. Okay. Same thing for perineorrhaphy? 18 MR. ORENT: Objection. And similarly, 19 I think these questions are designed to embarrass 20 or offend the witness. 21 MS. BYARD: No. I'm asking the 22 questions I need to ask, John. So I object to the 23 colloquy. 24 MR. ORENT: They're ridiculous 25 questions for a pathologist.</p>	<p>1 BY MS. BYARD: 2 Q. Okay. But as far as where these 3 devices pass in the anatomy, based on their 4 surgical placement, you haven't been able to tell 5 me that with specificity, because those are better 6 questions for a clinician; correct? 7 A. No -- 8 MR. ORENT: Objection. 9 THE WITNESS: -- this is not correct. 10 I know where they are placed. You are asking me 11 how they are placed, and this is the difference. 12 Because I don't need to know exact very 13 specific details how they are placed. But, in 14 general, where they are placed and what anatomical 15 sort of locations are they placed -- that's 16 generally what I need to understand. 17 If I need very specific questions, if 18 there is a very specific question for specific 19 diagnostic procedure, then I would go and consult 20 with clinician. Like a placement of a stent, which 21 artery it was placed in the heart, was it LED or it 22 was circumflex? I mean, these would be very 23 specific. So what kind of stent it was, so if I 24 cannot find it. 25 But you're asking me trocar incisions</p>

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<p>1 and other things. I mean, I receive specimen six 2 years later when all incisions are healed. 3 BY MS. BYARD: 4 Q. Does the location of the incision 5 help you understand where the device was 6 anatomically located when it was actually in the 7 patient's body? 8 A. It can be very long way from 9 incision to the placement of the device. So it may 10 or may not help, but most of the time -- 11 For example, if it's a hernia, if it's 12 open hernia, I know that there was incision from 13 skin. So it's open hernia surgery. 14 If it's laparoscopic, I know that the 15 access was laparoscopically. So it's a different 16 anatomical location. So a laparoscopic hernia 17 would be more of an intraperitoneal access. That 18 makes a difference. 19 If you put sling through incision one 20 centimeter to the left or right, it will not make a 21 difference. 22 Q. So whether -- 23 A. But it might make a difference for 24 a surgeon. 25 Q. So whether or not the sling is</p>	<p>1 edema within mesh compartments, as 2 well as innervation with nerve 3 ingrowth into the mesh compartments, 4 vascular abnormalities and mesh 5 degradation." 6 Did I read that all reasonably 7 correctly? 8 A. That's correct. 9 Q. How do you define chronic 10 lymphoplasmacytic -- 11 A. Cytic. 12 Q. -- cytic inflammation composed of 13 foreign body reaction? 14 A. Foreign body reaction, as I 15 explained before, is a collection of epithelioid 16 histiocytes, these are mononucleated or 17 multinucleated. Lymphoplasmacytic, as the word 18 implies, is lymphocytes and plasma cells. 19 Q. How do you define vascular 20 congestion? 21 A. If the vessels are enlarged, then 22 fully packed with red blood cells. 23 Q. What did you mean by "vascular 24 abnormalities"? 25 A. I see obliterated arteries. I see</p>
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<p>1 placed in the retropubic space as opposed to 2 through the transobturator space doesn't make a 3 difference to you as a pathologist? 4 A. It does make a difference. 5 As I said, this is an anatomical 6 location, that's what I'm -- I try to understand 7 every time I encounter a new device. But how it 8 was placed specifically, all intricate details of 9 surgical techniques, they're irrelevant for this. 10 Q. Moving to the third paragraph, the 11 third full paragraph on page 3, please, Doctor. 12 A. Yes. 13 Q. You write that you have been able to: 14 "Directly observe changes in 15 the mesh samples, including but not 16 limited to scar encapsulation, scar 17 maturation with contraction, the 18 inflammatory response to the 19 implanted mesh, including but not 20 limited to the foreign body reaction 21 and chronic lymphoplasmacytic 22 inflammation --" 23 A. Plasmacytic. 24 Q. Thank you. 25 "-- vascular congestion and</p>	<p>1 thrombosed capillaries. 2 Q. And for a lay person, what does 3 obliterated arteries and thrombose capillaries 4 mean? 5 A. A vessel which doesn't supply 6 blood anymore. 7 Q. Are you able to tell, 8 microscopically, when that obliteration occurred? 9 A. To a certain degree. 10 Q. How so? 11 A. Sometimes I can say that it's been 12 week or even month, maybe years, or sometimes it's 13 a relatively recent event, days. Or hours. 14 Q. But how do you discern that 15 microscopically, I think was my question? 16 A. Oh, then I would have to give you 17 a lecture. Vital response, the stages of tissue 18 reacting to a blocked vessel. 19 First, inflammatory cells, then there 20 would be changes in the vascular wall, organization 21 of the thrombus, recolonization. 22 Q. And so when you say you observe an 23 obliterated artery, for instance, would you 24 typically, as a pathologist, record whether or not 25 you saw these tissue reactions to the inciting</p>

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<p>1 event?</p> <p>2 A. Depends on clinical relevance.</p> <p>3 For example, if there is autopsy case</p> <p>4 and I see that the arteries in the heart is</p> <p>5 obliterated, it will depend. If it's an old</p> <p>6 injury, definitely it wasn't cause of death. If</p> <p>7 it's fresh injury, this can be cause of death.</p> <p>8 This is just an example.</p> <p>9 Q. And what is thrombosed capillary?</p> <p>10 What does that term mean for a lay person?</p> <p>11 A. Capillaries doesn't supply blood</p> <p>12 anymore.</p> <p>13 Q. Turning to your list of articles</p> <p>14 that you've set forth here, this list, did you</p> <p>15 intend it to include all of your publications,</p> <p>16 abstracts, lectures, oral and poster presentations</p> <p>17 pertinent to the subject of your report?</p> <p>18 A. Pertinent to my mesh research, yes.</p> <p>19 Q. Okay. All of these are from 2014,</p> <p>20 right?</p> <p>21 A. Yes.</p> <p>22 Q. I'd like to --</p> <p>23 A. Just one was earlier. When we</p> <p>24 started --</p> <p>25 Q. Oh, yes. "The Pathological</p>	<p>1 Carey and Dr. John Steege, "Pathology of Explanted</p> <p>2 Transvaginal Meshes," International Journal of</p> <p>3 Medical Health, Pharmaceutical and Biomedical</p> <p>4 Engineering, 2014; is that right?</p> <p>5 A. Correct.</p> <p>6 Q. The second is an article published</p> <p>7 with Dr. Bendavid, Dr. Lou and Koch, "Mesh-Related</p> <p>8 SIN Syndrome: A Surreptitious, Irreversible</p> <p>9 Neuralgia and Its Morphologic Background in the</p> <p>10 Etiology of Post-Herniorrhaphy Pain," International</p> <p>11 Journal of Clinical Medicine, 2014.</p> <p>12 These are both full published articles,</p> <p>13 right?</p> <p>14 A. Yes, these are full articles.</p> <p>15 Q. And then we have a list of</p> <p>16 abstracts. And there's five listed here, right?</p> <p>17 A. No, there are more. They're all</p> <p>18 included on the flash drive.</p> <p>19 Q. There are five listed here, right?</p> <p>20 A. On this page, yes, there are five.</p> <p>21 Q. How many more are there on that</p> <p>22 thumb drive?</p> <p>23 A. Maybe a couple. I don't remember now.</p> <p>24 Q. And you put this list together</p> <p>25 sometime around November 10th, 2014, right?</p>
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<p>1 Findings in Explanted Surgical Meshes," that</p> <p>2 presentation --</p> <p>3 A. Yes.</p> <p>4 Q. -- that you gave?</p> <p>5 A. The work, as I said, started in 2012.</p> <p>6 Q. For hernia mesh, right?</p> <p>7 A. Yeah. I think I received first</p> <p>8 transvaginal mesh very soon, January or February</p> <p>9 of -- or looked at it, I mean. It could have been</p> <p>10 St. Michael's Hospital transvaginal mesh, which is --</p> <p>11 I don't remember now.</p> <p>12 Q. Yeah, but 2013?</p> <p>13 A. All in 2013, yes.</p> <p>14 Q. Okay. All of these publications,</p> <p>15 though, with the exception of this oral</p> <p>16 presentation, are from 2014, right?</p> <p>17 A. Yes. Most of the work was done --</p> <p>18 completed in 2014.</p> <p>19 Q. And I understand the publication</p> <p>20 process takes some time, okay. That's not what I'm --</p> <p>21 I don't intend to quibble with you about that at</p> <p>22 all.</p> <p>23 I want to walk through these before we</p> <p>24 get into any detail in them. The first is an</p> <p>25 article that you published with Dr. Erin Teeter</p>	<p>1 A. October, November, yeah.</p> <p>2 Q. So the abstracts that are -- you</p> <p>3 have on your thumb drive, the abstracts that are in</p> <p>4 addition to this list that are available on this</p> <p>5 thumb drive, were published since November 10th of</p> <p>6 2014?</p> <p>7 A. Either published or presented. So</p> <p>8 I usually put something published or presented on</p> <p>9 my CV. Not something which was been accepted.</p> <p>10 Q. Okay.</p> <p>11 A. But sometimes depends. Sometimes</p> <p>12 I put something that has been accepted, but hasn't</p> <p>13 been presented.</p> <p>14 Q. Let's look at these five</p> <p>15 abstracts. The first one is published by you and</p> <p>16 Dr. Mekel and Blaivas?</p> <p>17 A. That's correct.</p> <p>18 Q. "Pathological Findings of</p> <p>19 Transvaginal Polypropylene Slings Explanted for</p> <p>20 Late Complications: Mesh Is Not Inert," the</p> <p>21 International Continence Society Annual Meeting,</p> <p>22 2014, right?</p> <p>23 A. That's correct.</p> <p>24 Q. And then the next one, Dunn,</p> <p>25 Guelcher and you: "Failure Analysis of Transvaginal</p>

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<p>1 Mesh Products: A Biomaterials Perspective Using 2 Materials Science Fundamentals," 2014. 3 A. That's correct. 4 Q. Number three is Vladimir Iakovlev: 5 "Explanted Surgical Meshes: What Pathologists and 6 Industry Failed to Do for 50 Years," 2014, right? 7 A. That's correct. 8 Q. Yourself, Dr. Guelcher and 9 Dr. Bendavid: "In-vivo Degradation of Surgical 10 Polypropylene Meshes: A Finding Overlooked for 11 Decades," 2014. Right? 12 A. That's correct. 13 Q. Number five is an abstract with 14 yourself, Dr. Erin Teeter Carey, Dr. Iakovleva -- 15 A. Yes. 16 Q. -- Dr. Steege and Dr. Bendavid: 17 "Pathological Findings Associated with Pain in 18 Transvaginal Meshes." 19 A. That's correct. 20 Q. 2014. 21 And then you list here some lectures 22 and oral presentations. 23 This first one, is a copy of that 24 included in materials that you've provided on the 25 thumb drive?</p>	<p>1 presentations forms of the articles and abstracts? 2 A. Not all of them. For the Canadian 3 hernia meetings, I was just invited to come without 4 abstracts. 5 Q. Okay. Can you point those out to me? 6 A. This, number one. 7 Q. Okay. 8 A. (Witness reviews document.) 9 This was just an invitation. Number 10 three, also just an invitation. Number five -- 11 Q. Okay. 12 A. -- this was just an invitation. 13 Yup. 14 MR. ORENT: When we get to a good 15 breaking point, we can take our first break. 16 MS. BYARD: Now is a fine time for me. 17 MR. ORENT: Okay. 18 THE VIDEOGRAPHER: This marks the 19 end of media number one, in the deposition of 20 Dr. Vladimir Iakovlev. 21 We're going off the record at 10:43 a.m. 22 -- RECESS AT 10:43 -- 23 EXHIBIT NO. 1197: Article entitled, 24 "Mesh-Related SIN Syndrome: A 25 Surreptitious Irreversible Neuralgia</p>
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<p>1 A. Yes. I included all what I could 2 at this stage, I mean, whatever I had. 3 Q. Okay. And number two, is that 4 essentially a duplication of the fully published 5 article number one on your list? 6 A. Well, it's a duplication of the 7 title. So what happens with some conferences or 8 other meetings, it's a bit an abstract. Abstract 9 is accepted, it's published either in special 10 journal issue, and then they make a decision, if 11 you make an oral presentation, or you make a poster 12 presentation. 13 So then abstract is duplicated as oral 14 presentation or poster presentation, because 15 abstract you describe your work to the peer review 16 process, and then there is a decision how you 17 present it. 18 So it becomes presented twice. One in 19 the form of abstract, and then one in the form of 20 presentation. Either oral presentation or poster 21 presentation. 22 Q. Okay. So for all these articles 23 and abstracts, the two articles, the five 24 abstracts, this list then of lectures and oral 25 presentations or poster presentations, are</p>	<p>1 and Its Morphologic Background in the 2 Etiology of Post-Herniorrhaphy Pain," 3 International Journal of Clinical 4 Medicine, 2014, by Dr. R. Bendavid, 5 Dr. W. Lou, Dr. A. Koch and Dr. V. 6 Iakovlev. 7 -- UPON RESUMING AT 11:03 -- 8 THE VIDEOGRAPHER: Here begins media 9 number two in the deposition of Dr. Vladimir 10 Iakovlev. 11 We're back on the record at 11:03 a.m. 12 BY MS. BYARD: 13 Q. Doctor, I'll hand you what's been 14 marked as 1197. Counsel. 15 MR. ORENT: Thank you. 16 BY MS. BYARD: 17 Q. Doctor, do you recognize Exhibit 1197? 18 A. Yes. 19 Q. What is it? 20 A. It's published article, 21 co-authored by me. 22 Q. So these other doctors listed on 23 the article are Dr. Bendavid, Dr. Lou and Dr. Koch; 24 do you see that? 25 A. Yes.</p>

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<p>1 Q. Do these doctors use mesh and 2 hernia repair, to your knowledge? 3 A. Yes. Except for Dr. Lou, she's a 4 statistician. 5 Q. Presently Dr. Bendavid continues 6 to use polypropylene mesh for the treatment of 7 abdominal hernia repair; correct? 8 MR. ORENT: Objection. 9 THE WITNESS: No. Actually, he uses 10 native tissue to repair. He takes out meshes. 11 BY MS. BYARD: 12 Q. Did there come a time when his 13 practice changed in that regard, to your knowledge? 14 A. It depends. I mean, in some 15 patients you just have no choice. You have to use, 16 like, um, central large defects. 17 Q. So he makes a patient -- your 18 understanding is that Dr. Bendavid makes a 19 patient-specific determination about whether or not 20 to use polypropylene mesh in hernia repair? 21 MR. ORENT: Objection. 22 THE WITNESS: That's correct. 23 BY MS. BYARD: 24 Q. Is the same true for Dr. Andreas 25 Koch?</p>	<p>1 A. That's correct. 2 Q. Would you describe this study as 3 having been controlled through the use of virgin 4 tissue and scar tissue? 5 A. No. As I said, control is a 6 specific statistical term for clinical prospective 7 studies. 8 Q. How would you describe this study 9 then? 10 A. This was a prospective study. 11 Q. Why was it important for the study 12 to use virgin tissue, scar tissue, and explanted 13 mesh specimens in comparison to one another? 14 A. There were two questions. First 15 question was, if nerve ingrowth occurs in the mesh 16 which has been reported even before this paper. 17 And the second question was, what's the 18 nerve density in comparison with virgin tissue and 19 scar without mesh. If mesh inhibits nerve 20 ingrowth; and if it inhibits, to what degree. Sort 21 of establishes a baseline for these parameters. 22 Q. So you used virgin tissue and scar 23 tissue in order to establish a baseline for the 24 comparison to mesh that you were making in terms of 25 nerve proliferation in tissue, correct?</p>
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<p>1 A. Koch. 2 MR. ORENT: Objection. 3 BY MS. BYARD: 4 Q. Koch? 5 A. Yes. 6 Q. Okay. Explain to the jury what a 7 controlled study is. 8 A. Where is the jury? 9 Q. (Indicates.) 10 A. Okay. You mean controlled 11 clinical study? 12 Q. Just in general, what a controlled 13 study is. Whether it's in a clinical setting, or 14 in your laboratory? 15 A. "Controlled" usually implies to a 16 clinical study, so if it's in a laboratory it 17 wouldn't be controlled. 18 Controlled is a prospective study where 19 patients are registered and specific statistical 20 requirements for this. 21 Q. In this study with Dr. Bendavid, 22 you used ten specimens, in three groups; in each of 23 three groups. You looked at virgin tissue, you 24 looked at scar tissue, and you looked at explanted 25 mesh from the posterior inguinal wall; correct?</p>	<p>1 A. Mesh and scar were more of a 2 controls in this study. I mean virgin, was more of 3 a control. But baseline was between all of those 4 three types of tissue. 5 Q. So explain to the jury what you 6 mean by "control". 7 MR. ORENT: Objection. 8 THE WITNESS: I didn't mean control. 9 Where did I say "control"? Control, you mean 10 control samples? 11 BY MS. BYARD: 12 Q. Yes. 13 A. Sorry, I misunderstood you. 14 Control sample is a sample which is 15 used for comparison, something which implies 16 doesn't have any changes. 17 Something neutral, normal, or something 18 which has been exposed to only methodology 19 manipulations, rather than biological processes 20 which are being studied. 21 BY MS. BYARD: 22 Q. And similarly, you've used scar 23 tissue in this study as a control to understand if 24 there were differences related to the mesh? 25 A. Yes. So mesh is encapsulated by</p>

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<p>1 scar tissue. So control for scar around and inside</p> <p>2 the mesh would be scar without mesh. So the same</p> <p>3 area, surgical procedure, all of those are</p> <p>4 variables are the same, except one group has mesh</p> <p>5 and the other group doesn't have mesh.</p> <p>6 Q. Other terms that are used to</p> <p>7 describe study designs include "randomized studies"</p> <p>8 or "blinded studies"; are you familiar with those</p> <p>9 terms?</p> <p>10 A. Yes, I am.</p> <p>11 Q. Is it fair to say that this was a</p> <p>12 controlled study, but not randomized or blinded?</p> <p>13 A. You're just using it in different --</p> <p>14 randomized, controlled studies -- these are all</p> <p>15 clinical terms, specific statistical methods for</p> <p>16 clinical prospective studies when a drug is tested</p> <p>17 or a new device is tested. So the patients are</p> <p>18 randomized before they are given treatment. And</p> <p>19 then they follow this cohorts. And then there is</p> <p>20 statistical methods to follow that, and there are</p> <p>21 specific requirements for that.</p> <p>22 In this case, it's not applicable,</p> <p>23 because there were no new device, no new medication</p> <p>24 introduced. And the randomization is done before</p> <p>25 the device is being inserted, or new medication is</p>	<p>1 for nerve density, nerve size, and nerve and vessel</p> <p>2 ingrowth, correct?</p> <p>3 A. That's correct. Well, we assessed</p> <p>4 the specimen, so we observed what was abnormal in</p> <p>5 the microscope. So the main hypothesis and main</p> <p>6 focus was nerve ingrowth, but then there were other</p> <p>7 microscopic findings within mesh specimens which</p> <p>8 were observed.</p> <p>9 Q. You found that there were no</p> <p>10 significant differences in nerve density between</p> <p>11 virgin scar and mesh samples, correct?</p> <p>12 A. Yeah, that's correct. In that</p> <p>13 sample size, there was no statistical significant</p> <p>14 difference.</p> <p>15 Q. You concluded that the presence of</p> <p>16 mesh does not significantly affect nerve density,</p> <p>17 right?</p> <p>18 A. It's the same statement as before.</p> <p>19 Q. You concluded that -- you</p> <p>20 concluded, though, that the nerves and their</p> <p>21 terminal ends were in a vulnerable position about</p> <p>22 the mesh and within its pores?</p> <p>23 A. That was additional findings,</p> <p>24 because we observed changes of the scar tissue</p> <p>25 within the mesh, because it was different from the</p>
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<p>1 given. You cannot randomize it after. So it's</p> <p>2 completely different, we are talking about</p> <p>3 completely different scenarios.</p> <p>4 Q. Well, and it wasn't blinded in the</p> <p>5 sense that you knew whether the specimen that you</p> <p>6 were looking at was native tissue or virgin tissue,</p> <p>7 whether it was scar tissue or whether it was mesh,</p> <p>8 correct?</p> <p>9 A. Blinded, again, it's more of a</p> <p>10 clinical terminology when you do controlled</p> <p>11 studies.</p> <p>12 So either patients are blinded, or</p> <p>13 researchers are blinded. I mean, there was a</p> <p>14 degree of blindness in this study. But again,</p> <p>15 talking about completely different statistical</p> <p>16 scenarios, completely different approaches.</p> <p>17 Q. What do you mean by, there was a</p> <p>18 degree of blinded in this study?</p> <p>19 A. When I was examining them, I was</p> <p>20 examining them without knowledge of other clinical</p> <p>21 variables. I could clearly see that there's no</p> <p>22 mesh in it; if it's scar or not scar.</p> <p>23 But then I didn't know if there were</p> <p>24 comorbidities, other possible clinical variables.</p> <p>25 Q. So here you examined the samples</p>	<p>1 scar without the mesh.</p> <p>2 Q. How so?</p> <p>3 A. It's all described in the paper.</p> <p>4 There are vascular congestion, edema, inflammation,</p> <p>5 foreign body type, chronic lymphoplasmacytic</p> <p>6 inflammation.</p> <p>7 (Reporter sought clarification.)</p> <p>8 A. Foreign body type inflammation,</p> <p>9 and chronic lymphoplasmacytic inflammation.</p> <p>10 MR. ORENT: L-Y-M-P-H-O-P-L-A-S-M-A-C-Y-T-I-C</p> <p>11 BY MS. BYARD:</p> <p>12 Q. What did you mean by "in a</p> <p>13 vulnerable position"?</p> <p>14 A. In a pathologically changed</p> <p>15 tissue, mainly it is compartmentalization of the</p> <p>16 mesh. So what happens, the scar tissue within the</p> <p>17 mesh is divided into compartments. So,</p> <p>18 essentially, there are little gates or bottlenecks</p> <p>19 in the mesh. And this mainly causes the problem.</p> <p>20 Because it's compartment, it's enclosed</p> <p>21 compartment. Like tooth pulp, this is best</p> <p>22 analogy. It gets inflamed; you feel pain.</p> <p>23 Q. You didn't write here, though,</p> <p>24 that the compartmentalization of nerves in mesh is</p> <p>25 what caused clinical complications in these</p>

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<p style="text-align: right;">Page 90</p> <p>1 patients. You wrote that they were in a vulnerable 2 position, correct? 3 A. In the text, I think there is 4 compartmentalization discussion. 5 Q. Well, what you wrote, though, was 6 that nerve receptors were exposed to potential 7 mechanical and chemical factors: Scarring, 8 entrapment, compression, tugging, deformation, 9 contraction, hypoxia/acidosis, inflammation and 10 edema. That's what you wrote; correct? 11 A. That's an abstract. 12 MR. ORENT: Objection. 13 THE WITNESS: You're reading an 14 abstract. I'm saying that there is discussion 15 longer in the text. 16 BY MS. BYARD: 17 Q. Is that what appears in the 18 abstract, sir? 19 A. You just read it, yes. 20 Q. In the introduction, the last 21 sentence reads: 22 "The mesh in question is 23 polypropylene, the most widely used 24 polymer in hernia repair." Correct? 25 A. That's correct.</p>	<p style="text-align: right;">Page 92</p> <p>1 what I think is -- well, usually, it is what is 2 available. 3 If it's a large POP device, I submit 4 representative sections. Usually not more than 5 three blocks. I never needed to submit more 6 tissue. Either I submitted everything, or it was 7 satisfactory for examination to submit what I 8 submitted first time. 9 BY MS. BYARD: 10 Q. What do you mean by 11 "representative sections"? 12 A. Representative of the sample. 13 Q. And how do you determine that? 14 A. According to my training and 15 experience. 16 Q. Are you taking, though, when you 17 examine transvaginal mesh specimens, are you taking 18 samples or sections that you determine are 19 representative based on your training? 20 A. Yes. 21 MR. ORENT: Objection. 22 BY MS. BYARD: 23 Q. In the second full paragraph under 24 methods you write: 25 "If a peripheral nerve was seen</p>
<p style="text-align: right;">Page 91</p> <p>1 Q. There's a discussion here under 2 your methods, that the mesh samples -- 3 "The mesh specimens were 4 sampled initially by two blocks, and 5 then if nerve ingrowth was not 6 detected within the initial two 7 blocks, additional blocks were taken 8 until penetration was directed." 9 Do you see that? 10 A. "Detected". 11 Q. Thank you. Do you see that? 12 A. Yes. 13 Q. Did you perform the same type of 14 sampling for microscopic evaluation in your 15 examinations of transvaginal mesh? 16 A. No, there was no need. The nerve 17 density is so much higher in transvaginal meshes, 18 that pretty much very small piece would contain it. 19 Q. So unlike this study on hernia 20 mesh, for transvaginal mesh you didn't initially 21 sample the specimens to determine if you could 22 detect nerve ingrowth or not? 23 MR. ORENT: Objection. 24 THE WITNESS: For transvaginal meshes I 25 don't submit additional sections. I just submit</p>	<p style="text-align: right;">Page 93</p> <p>1 an imaginary line connecting the 2 outermost points of adjacent mesh 3 filaments, it was recorded as nerve 4 ingrowth into the mesh pore." 5 Right? 6 A. That's correct. 7 Q. Tell me what you mean by 8 "imaginary line"? 9 A. Do you want me to draw or -- that 10 would be easier. 11 Q. We might do that later. Can you 12 try and explain it to me in words? 13 A. Essentially this describes the 14 boundaries of a mesh area, area which is occupied 15 by mesh, which by definition would be new tissue. 16 Tissue which appeared after the mesh was placed. 17 Q. So when you look at a slide, you 18 see either a clear space or a whole space where you 19 determine that the mesh was or is and can't be 20 seen, right? 21 MR. ORENT: Objection. 22 THE WITNESS: What I see in the 23 microscope, I see cross-sections of the filaments, 24 they are clear, yes, you are right. 25 So I can see the outermost points of</p>

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<p>1 the mesh filaments. Therefore, anything inside 2 this boundaries, is new tissue which was generated 3 after mesh was placed. 4 It was an artificial sort of 5 distinction for us to understand during this study, 6 which nerves were new, new innervation or 7 reinnervation. And which nerves could have been 8 trapped in the scar which was expanding into normal 9 tissue. 10 BY MS. BYARD: 11 Q. To identify when looking -- let me 12 start over. 13 When looking at transvaginal mesh 14 slides under microscope, you have to draw the same 15 imaginary line connecting the outermost points of 16 the adjacent mesh filaments in order to record 17 whether nerves are ingrown in the mesh, are whether 18 they were preexisting, correct? 19 A. Yes, I mean this would be a very 20 strict criteria. Because some nerve branches just 21 outside of the imaginary line can still be new 22 ones. But, I mean, anything beyond those lines is 23 new, by definition. 24 But the one I assess, I make a 25 distinction. Especially if I collect data for</p>	<p>1 Q. And this same process that you 2 describe here in this study of drawing an imaginary 3 line connecting the outermost points of the 4 adjacent mesh filaments, is the same process by 5 which you determined the shape of the mesh when 6 looking at transvaginal specimens, correct? 7 A. No, I don't understand your 8 question. Shape in nerves -- they are different 9 issues. 10 Q. Okay. Let me take it then the way 11 that you've presented it. 12 This same process that you describe in 13 the study of drawing an imaginary line connecting 14 the outermost points of adjacent mesh filaments, in 15 order to determine whether nerves were there 16 beforehand, or whether they grew into the mesh, is 17 the same method that you applied to your analysis 18 of transvaginal mesh specimens in the litigation, 19 correct? 20 A. In litigation, I describe nerve 21 involvement. I mean, they might be ingrown; they 22 might be just outside. 23 As I said, diagnostically, if the nerve 24 is affected, it could be outside of the imaginary 25 line. It can be trapped in the scar tissue or</p>
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<p>1 research product. But for symptoms as a diagnostic 2 tool, it doesn't have much significance. 3 Because as I said, I mean, nerves 4 right -- just outside that line, can be affected to 5 the same degree as -- it might be microns 6 difference, here or there, so -- but that was 7 important for this study, to understand it as 8 diagnostically this doesn't have much significance. 9 Q. Do you know, or did your -- I'm 10 sorry, let me start over. 11 Did your research here, look at how, 12 diagnostically, nerves growing outside of mesh or 13 preexisting nerves, compared in terms of clinical 14 complications to nerves growing within the mesh? 15 A. In this study? 16 Q. (Nods.) 17 A. In this study, we, as I said, 18 establish baseline. 19 Q. So the answer to my question is, 20 "no, you did not," right? 21 MR. ORENT: Objection. 22 THE WITNESS: Well, you see that there 23 is no specific correlation with clinical 24 presentation in this specific study. 25 BY MS. BYARD:</p>	<p>1 around. 2 I think it is a little artificial to 3 hook on this imaginary line. It was done for the 4 research project. As I said, diagnostically, what 5 matters is, if there is an innervation in the 6 tissue, in that tissue. That's important. 7 Q. To determine whether or not a 8 nerve had ingrown into mesh, though, when you were 9 looking at transvaginal mesh specimens, you had to 10 draw this imaginary line connecting the outermost 11 points of adjacent mesh filaments? 12 A. If I want to call it ingrown, yes, 13 it's important. But diagnostically, is it -- if 14 only ingrown nerves are important for diagnostic 15 purposes, this is not correct. 16 Because ingrown nerves which are inside 17 the compartment, they are much deeper. But at the 18 same time, if a nerve is just outside, it branches, 19 and then supplies nerve endings, small branches in 20 the tissue inside. 21 Q. Please listen to my question, sir. 22 In order to determine whether nerve was 23 ingrown in mesh, when examining transvaginal mesh 24 specimens, you had to draw this same imaginary line 25 that you describe in your study with Bendavid,</p>

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<p>1 connecting the outermost points of adjacent mesh 2 filaments, didn't you? 3 MR. ORENT: Objection. Asked and 4 answered. Moreover, Dr. Iakovlev is entitled to 5 give a full and complete response to the questions 6 and he will continue to do so and -- 7 MS. BYARD: Please limit your 8 objections to form, sir. 9 MR. ORENT: Asked and answered. 10 THE WITNESS: As I said, in the 11 description if I say ingrown, I use this imaginary 12 line. But diagnostically, this has not -- it 13 doesn't have much significance. Because what I do 14 in diagnostically, I try to estimate or assess if 15 the tissue is innervated. That's what important. 16 BY MS. BYARD: 17 Q. But whether you determine that a 18 nerve was ingrown, depends completely on whether it 19 lies within the parameters of this imaginary line 20 that you've drawn? 21 MR. ORENT: Objection. Asked and 22 answered. 23 THE WITNESS: Ingrown where? Ingrown 24 in the scar, or ingrown inside the mesh? 25 BY MS. BYARD:</p>	<p>1 MR. ORENT: Objection. 2 THE WITNESS: No. 3 BY MS. BYARD: 4 Q. And so you didn't adjust -- 5 calculate an adjustment ratio, and your examination 6 and analysis of transvaginal mesh for litigation, 7 correct? 8 MR. ORENT: Objection. 9 THE WITNESS: Again, we are going from 10 research from scientific question to diagnostic 11 processes. 12 I don't base my opinion on adjustment 13 ratios or on the specifics of what I did in the 14 research part. I don't -- 15 BY MS. BYARD: 16 Q. My only question is whether you 17 did it? 18 A. I never used it. It was only used 19 once for this specific study, for specific 20 question. It wasn't diagnostic question. It was 21 more of a mathematical question. 22 Q. I want to turn to page 802 of 1197. 23 The last two full sentences before the 24 figures read: 25 "The branches located at the</p>
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<p>1 Q. Ingrown inside the mesh, please. 2 A. If it's ingrown inside the mesh 3 and I make a statement -- 4 MR. ORENT: Objection. 5 THE WITNESS: -- that it was beyond 6 that imaginary line, diagnostically it does not 7 matter. Because it can be ingrown in the scar, it 8 innervates the tissue. 9 I think we are mixing up diagnostic 10 process with our research. 11 Descriptive term can be, if I make a 12 statement if it's ingrown in the mesh, I used that 13 imaginary line. 14 BY MS. BYARD: 15 Q. Thank you. 16 Part of what you did in the study with 17 Dr. Bendavid included calculating an adjustment 18 ratio between specimens to come to a more accurate 19 picture of the rate of nerve ingrowth, correct? 20 A. Not rate, density. 21 Q. Density, thank you. 22 With respect to your examination of 23 transvaginal mesh for the litigation, you didn't 24 evaluate nerve density at the technical level that 25 you did for the study on hernia repair; correct?</p>	<p>1 mesh interface tended to have an 2 orientation parallel to the mesh 3 plane." 4 A. That's correct. 5 Q. "Some branches showed a coarse 6 angled to the mesh plane, and nine 7 out of the ten specimens, 90 8 percent, showed penetration of 9 nerves into the mesh structure. 10 Table 1." 11 A. That is correct. 12 Q. What do you mean by, "the branches 13 at the mesh interface tending to have an 14 orientation parallel to the mesh plane"? 15 A. They had orientation parallel to 16 the mesh plane. 17 Q. So the majority of the nerves that 18 were located at the mesh interface were running 19 parallel to the mesh as opposed to through it? 20 A. Yes, that's how you would orient 21 any cable. Just think about cables. There's a 22 cable, and then you run it in the corner because 23 there is an obstacle here, and then there are 24 branches which go into the ceiling, or the walls, 25 or somewhere else; so you can imagine the same way.</p>

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<p>1 Nerve branch goes along the plane, and 2 then there are small branches going into the mesh 3 and they innervate inside tissue. It's logical 4 biological. 5 Q. Is this same finding -- let me 6 start over. 7 Were your findings about the 8 orientation of the branches of nerves located at 9 the mesh interface similar for transvaginal mesh as 10 you've described here for hernia mesh? 11 A. Transvaginal mesh is different 12 because there are no anatomical planes. In the 13 hernia, in the anterior abdominal wall, you have 14 layers which are separated by fascia, serrated 15 muscle, so there are anatomical planes. 16 In transvaginal location, there is no 17 anatomical plane. Tissues just merge into each 18 other. The orientation of nerves is a little bit 19 different, because in the anterior abdominal wall, 20 most of the nerves run parallel to supply further; 21 so the mesh is placed parallel. 22 In the transvaginal location, the nerve 23 branches are running to innervate mucosa. And the 24 mesh is placed perpendicular, so this is completely 25 a different anatomical structure.</p>	<p>1 A. No, this is not my testimony. 2 It's higher. And on an average, the last time I 3 calculated, it's about six times higher. What is 4 an average number of nerves I see, and I'm talking 5 about densities, which was about six times higher. 6 Number of nerves I see, I don't know 7 now. It's much higher. I mean, it's definitely 8 not one to three, it's about beyond ten or so. 9 And then it depends, I mean, what 10 device we are talking about. Sling, slings tend to 11 have smaller specimens. POP devices, it might be 12 over a hundred of nerves that I see in one section, 13 it depends. 14 Q. So the way you went about arriving 15 at this number for your valuation of hernia repair, 16 was to actually count the number of nerves per 17 specimen, correct? 18 A. That's correct. 19 Q. And you haven't done that counting 20 activity for transvaginal mesh specimens? 21 A. I have not. 22 MR. ORENT: Objection. 23 THE WITNESS: There are reports, 24 completed surgical pathology reports with synoptic 25 data, and there is a full count.</p>
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<p>1 So in transvaginal meshes, they are all 2 over the place, and I did not see that predominance 3 of parallel orientation. It's different anatomical 4 structure. 5 Q. You write that the number of 6 nerves ingrown -- and I've switched to page 803. 7 On page 803, the first full sentence you write: 8 "The number of nerves ingrown 9 into the mesh structures range from 10 one to three per examined portion of 11 a specimen." 12 Correct? 13 A. That's correct. 14 Q. Were your findings in examining 15 transvaginal mesh specimens similar to your 16 findings here on hernia mesh? 17 A. No. Densities are much higher in 18 transvaginal meshes. About six times on average 19 than in inguinal hernia. 20 Q. So when you see the number of 21 nerves ingrown into mesh structures and hernia 22 repair ranging from one to three per examined 23 portion of the mesh; the number would be closer to 24 6 to 18 nerves per examined specimen for 25 transvaginal mesh? Is that your testimony?</p>	<p>1 Again, it's not what I am basing my 2 opinion, but this was done more for research 3 purpose later on. 4 BY MS. BYARD: 5 Q. Okay. So in answer to my 6 question, you haven't done this type of overall 7 analysis of counting the nerves, the number of 8 nerves that you see grown into mesh structure for 9 transvaginal mesh, right? 10 MR. ORENT: Objection. Asked and 11 answered. 12 THE WITNESS: I have done it. When the 13 complete surgical report is issued, it contains 14 these numbers. 15 BY MS. BYARD: 16 Q. Whose complete surgical report? 17 A. There's some, I think I completed 18 it to -- when I sign out a surgical pathology 19 report in St. Michael's system, I include full 20 analysis for nerve report -- nerve densities. 21 Q. So there are some cases where 22 you've completed a complete St. Michael's surgical 23 pathology report and others where you haven't, 24 correct? 25 A. For most of this, I didn't have</p>

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<p>1 time to complete the surgical pathology reports. 2 But you have at least one here, I think 3 for Ms. Holland. 4 MR. ORENT: Tab 1. 5 BY MS. BYARD: 6 Q. I know what you're referring to 7 and we'll look at that tomorrow. 8 A. Okay. 9 Q. Take the time you need, I know 10 what you're referring to, though. 11 A. So how this is done, when I -- 12 Q. That's okay, there's no question 13 pending. 14 MR. ORENT: That's the report you're 15 looking for? 16 THE WITNESS: Yeah, the densities here, 17 right there. 18 BY MS. BYARD: 19 Q. So my question is focused on your 20 analysis -- which case is that? 21 A. This one. 22 MR. ORENT: Lucy Allen. 23 MS. BYARD: Okay. 24 (Reporter sought clarification). 25 MR. ORENT: Lucy Allen.</p>	<p>1 question. 2 A. I've done it. 3 MR. ORENT: Objection. 4 THE WITNESS: You asked me if I've done 5 it for 120. I've done the count for those which 6 were completed cases. 7 I have stacks of cases at different 8 stages of completion. It's work in progress for 9 some of them. But with the cases completed, 10 altogether with a surgical pathology report, there 11 is count. For each single specimen completed, 12 there is count of nerves and nerve densities. 13 BY MS. BYARD: 14 Q. And of the 25-plus cases we will 15 talk about tomorrow, you have one example of that, 16 right? 17 MR. ORENT: Objection. Misstates his 18 testimony. 19 THE WITNESS: Not example. One case is 20 completed in that respect. 21 BY MS. BYARD: 22 Q. Okay. And the range of the number 23 of nerves ingrown into mesh structures for 24 transvaginal mesh in the 120 specimens that are 25 detailed in your report, doesn't appear in your</p>
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<p>1 And he's pointing to the line that 2 reads, "was it 59 branches?" 3 BY MS. BYARD: 4 Q. Okay. So my question is focused 5 on the 120 specimens that are talked about in your 6 report. 7 You didn't perform an analysis of the 8 number of nerves in each individual specimen of 9 those 120 that you examined, in order to arrive at 10 a range of averages of the number of branches 11 ingrown into mesh structures for transvaginal mesh? 12 MR. ORENT: Objection. 13 THE WITNESS: I have done for large 14 part of those. Those counts are done for large 15 number of this specimens. 16 BY MS. BYARD: 17 Q. That doesn't appear in your 18 report, does it? 19 A. Which, which report? 20 Q. In your report, Exhibit 197? 21 A. Which one? I don't understand. 22 Q. Or 196. 23 A. On the general report? As I said, 24 it doesn't have diagnostic significance. 25 Q. So it wasn't done? That's my only</p>	<p>1 report, does it? 2 MR. ORENT: Objection. 3 THE WITNESS: No, I didn't record it. 4 Because I'm not basing my opinion for that specific -- 5 for this specific purpose we are here today. 6 BY MS. BYARD: 7 Q. Okay. And, Doctor, if there are 8 reasons why things were included or not included, 9 your counsel can ask you about that. I just am 10 asking you if it's there or not, okay? 11 You conclude this paragraph on page 803 12 of Exhibit 1197 by saying: 13 "These one to three ingrown 14 nerves into the pores constituted a 15 median of 6.3 percent range, 16 2.17 percent to 15.8 percent of all 17 nerves seen within the examined 18 tissue." 19 A. That's correct. 20 Q. Here you compared the number of 21 nerves ingrown into pores with the number of nerves 22 that were seen in the examined tissue as a whole? 23 A. Yes. I mean, so this is a 24 percentage of those nerves which were seen ingrown, 25 with those three criteria we discussed earlier.</p>

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<p>1 Q. And compared to the number of</p> <p>2 nerves that were in the examined tissue overall,</p> <p>3 the number of nerves that were grown into pores,</p> <p>4 was a median of 6.3 percent with a range of 2.17 to</p> <p>5 15.8 percent, correct?</p> <p>6 A. That's correct.</p> <p>7 Q. Have you performed this same</p> <p>8 statistical analysis for the transvaginal mesh</p> <p>9 specimens?</p> <p>10 A. For those I completed test, I</p> <p>11 mean, it's somewhere in the spreadsheet. I started</p> <p>12 testing that as well. But it's only when the nerve</p> <p>13 count is completed that I can do it.</p> <p>14 Q. So it's not in your report, is it?</p> <p>15 A. No. It has no diagnostic</p> <p>16 significance. One nerve is enough. I mean, if you</p> <p>17 have one nerve in the tooth and it hurts, it's just</p> <p>18 one nerve is enough.</p> <p>19 MS. BYARD: Object and move to strike</p> <p>20 after the words, "No, it's not in the report."</p> <p>21 MR. ORENT: Oppose.</p> <p>22 BY MS. BYARD:</p> <p>23 Q. Do you know how the percentage of</p> <p>24 nerve ingrowth in transvaginal mesh samples within</p> <p>25 mesh structures compares to the number of nerves in</p>	<p>1 scientific question, I will complete it. But</p> <p>2 again, the conclusions in this paper were not based</p> <p>3 on this number. This number was provided for</p> <p>4 readers to understand what is going on.</p> <p>5 BY MS. BYARD:</p> <p>6 Q. Could you tell me, sitting here</p> <p>7 today, what percentage of nerves you would expect</p> <p>8 to be ingrown compared to not ingrown and present</p> <p>9 in tissue for transvaginal mesh?</p> <p>10 A. At least the same as in hernia.</p> <p>11 As I said, likely several fold higher as well,</p> <p>12 because of difference in anatomical orientation.</p> <p>13 As I said, in transvaginal location,</p> <p>14 there are branches that going to innervate mucosa,</p> <p>15 so they're perpendicular to the mesh. So I'm</p> <p>16 expecting to see much higher percentage.</p> <p>17 Q. That's a working hypothesis at</p> <p>18 this point, but not a scientific conclusion arrived</p> <p>19 at through the same type of statistical analysis --</p> <p>20 MR. ORENT: Objection.</p> <p>21 BY MS. BYARD:</p> <p>22 Q. -- right?</p> <p>23 A. Yes, this is. But it will be at</p> <p>24 least 6.3 percent. Again, diagnostically, it's</p> <p>25 irrelevant. For specific patients, for specific</p>
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<p>1 transvaginal mesh specimens overall?</p> <p>2 MR. ORENT: Objection.</p> <p>3 THE WITNESS: I think I answered that</p> <p>4 generally, density is about six times higher. I</p> <p>5 mean, it depends on how you group those devices.</p> <p>6 If you split them into slings versus POP devices,</p> <p>7 but generally several fold higher.</p> <p>8 BY MS. BYARD:</p> <p>9 Q. That's true across the tissue</p> <p>10 specimen, though, correct?</p> <p>11 A. Transvaginal. If we compare</p> <p>12 transvaginal versus inguinal hernia, that's true.</p> <p>13 Q. What I am focused on now is the</p> <p>14 amount of nerves growing into the mesh pores</p> <p>15 compared to the amount of nerves overall. And we</p> <p>16 know from your study that it's around 6.3 percent</p> <p>17 for inguinal hernia repair mesh.</p> <p>18 I'm asking if you have a percentage for</p> <p>19 me of the percentage rate of nerve ingrowth into</p> <p>20 compartmentalized pores for transvaginal mesh as</p> <p>21 compared to the number of tissues overall in the</p> <p>22 specimens that you've examined?</p> <p>23 MR. ORENT: Objection.</p> <p>24 THE WITNESS: As I said, that work is</p> <p>25 not completed. It is not done yet. If there is a</p>	<p>1 purpose we're here today.</p> <p>2 Q. And here you have this nerve</p> <p>3 assessment data Table 1 on page 804.</p> <p>4 A. Yes.</p> <p>5 Q. And the transvaginal specimen</p> <p>6 analysis that you have done, did you compare virgin</p> <p>7 tissue and scar tissue with actual samples?</p> <p>8 A. No --</p> <p>9 MR. ORENT: Objection.</p> <p>10 THE WITNESS: -- I mean I don't</p> <p>11 understand why you're asking these questions. And</p> <p>12 I didn't complete -- this was different study and</p> <p>13 just, I mean, this is -- again, as I said, this is</p> <p>14 not diagnostically relevant.</p> <p>15 MS. BYARD: Object and move to strike</p> <p>16 everything besides, "no."</p> <p>17 MR. ORENT: So are you suggesting by</p> <p>18 your repeated motions to strike, that he's not</p> <p>19 entitled to give a full answer?</p> <p>20 MS. BYARD: I don't think I have to</p> <p>21 answer your question for the basis of my motion.</p> <p>22 I just -- my questions are simple, and</p> <p>23 we're going to be here a long time if I can't just</p> <p>24 get answers to my questions.</p> <p>25 MR. ORENT: I think that's what he is</p>

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<p>1 doing. And I think you're going beyond the scope</p> <p>2 of what he's even intending to offer at trial. So</p> <p>3 if we stick to his opinions, we can move fast, too.</p> <p>4 But, Doctor, you can go ahead and keep</p> <p>5 answering your questions as you see fit.</p> <p>6 BY MS. BYARD:</p> <p>7 Q. So here for this study, you've</p> <p>8 used control samples, haven't you?</p> <p>9 A. For this study, yes.</p> <p>10 Q. You used the control sample in</p> <p>11 virgin tissue?</p> <p>12 MR. ORENT: Objection. Asked and</p> <p>13 answered.</p> <p>14 THE WITNESS: Yes.</p> <p>15 BY MS. BYARD:</p> <p>16 Q. You used another control sample in</p> <p>17 scar tissue, correct?</p> <p>18 MR. ORENT: Objection. Asked and</p> <p>19 answered.</p> <p>20 THE WITNESS: Scar tissue was control</p> <p>21 and at the same time, it was a test group depending</p> <p>22 on how we compare them.</p> <p>23 BY MS. BYARD:</p> <p>24 Q. In your report on your 120</p> <p>25 specimens for transvaginal mesh, you don't have a</p>	<p>1 BY MS. BYARD:</p> <p>2 Q. That's not in your report?</p> <p>3 A. That's for research, the report is</p> <p>4 diagnostic. Again, the same issue. We are mixing</p> <p>5 up unmixable things. Research and diagnostic work.</p> <p>6 Q. That's not in your report is it,</p> <p>7 sir?</p> <p>8 MR. ORENT: Objection.</p> <p>9 THE WITNESS: There is no statistics of</p> <p>10 comparison at all, because my reports are</p> <p>11 diagnostic reports, and this is research.</p> <p>12 BY MS. BYARD:</p> <p>13 Q. So you agree with me it doesn't</p> <p>14 appear in your report?</p> <p>15 MR. ORENT: Objection. Asked and</p> <p>16 answered for the fourth time.</p> <p>17 THE WITNESS: There was no research</p> <p>18 methodology or -- the reports are not research</p> <p>19 project. They are reports.</p> <p>20 BY MS. BYARD:</p> <p>21 Q. So the answer to my question is,</p> <p>22 no, that control group in virgin tissue is not set</p> <p>23 forth or analyzed in your report in the litigation?</p> <p>24 MR. ORENT: Objection.</p> <p>25 THE WITNESS: It's not mentioned, but I</p>
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<p>1 control group in virgin tissue?</p> <p>2 A. This is research. This is</p> <p>3 diagnostic work. We are mixing things which are</p> <p>4 completely unmixable. I just don't understand why</p> <p>5 we are doing this.</p> <p>6 Q. Please answer my question.</p> <p>7 MR. ORENT: Objection. Asked and</p> <p>8 answered.</p> <p>9 THE WITNESS: This is research. This</p> <p>10 is diagnostic work. Can you repeat the question so</p> <p>11 I understand what we are talking about, research or</p> <p>12 diagnosis?</p> <p>13 MS. BYARD: Would you mind reading back</p> <p>14 my question, Madam Court Reporter?</p> <p>15 REPORTER'S NOTE: Whereupon the</p> <p>16 question was read back as follows:</p> <p>17 "In your report on your 120</p> <p>18 specimens for transvaginal mesh, you</p> <p>19 don't have a control group in virgin</p> <p>20 tissue?"</p> <p>21 MR. ORENT: Objection.</p> <p>22 THE WITNESS: I do. There are samples</p> <p>23 in St. Michael's Hospital of transvaginal mucosa</p> <p>24 excised. So when the study is completed, I intend</p> <p>25 to examine those as well.</p>	<p>1 know about the mesh tissue, or human body</p> <p>2 interactions based on this study.</p> <p>3 So in order to produce this report, I</p> <p>4 used my knowledge, which I gained through my</p> <p>5 training, through this study and other studies, and</p> <p>6 then I make conclusions in diagnostic report. I</p> <p>7 could not put everything which I know or which --</p> <p>8 or research studies I've done and the reports.</p> <p>9 BY MS. BYARD:</p> <p>10 Q. Have you done an analysis of nerve</p> <p>11 assessment data on vaginal virgin tissue?</p> <p>12 MR. ORENT: Objection.</p> <p>13 THE WITNESS: As I said, it's work in</p> <p>14 progress. It will be done when I complete.</p> <p>15 BY MS. BYARD:</p> <p>16 Q. To date, it hasn't been completed?</p> <p>17 MR. ORENT: Objection.</p> <p>18 THE WITNESS: No.</p> <p>19 BY MS. BYARD:</p> <p>20 Q. And the same thing is true for</p> <p>21 vaginal scar tissue, correct?</p> <p>22 A. As I said, it was not a question</p> <p>23 for the reports. The reports describe pathological</p> <p>24 findings which I see, which I know pathological</p> <p>25 already.</p>

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<p>1 We're talking about research questions. 2 Sometimes it's question which is not relevant 3 specifically to diagnostic process. 4 Q. The answer to my question is that, 5 no, that analysis has not been completed to date, 6 right? 7 MR. ORENT: Objection. 8 THE WITNESS: The answer is, yes, I 9 have not completed the analysis of transvaginal 10 meshes for research purpose. 11 BY MS. BYARD: 12 Q. And I'm focusing on an analysis of 13 vaginal scar tissue. 14 MR. ORENT: Is there a question there? 15 BY MS. BYARD: 16 Q. Same question for vaginal scar 17 tissue. 18 MR. ORENT: Objection to form. 19 THE WITNESS: That, that's correct. 20 BY MS. BYARD: 21 Q. You write that you: 22 "Detected no indication that 23 the scar around and within the mesh 24 has significantly lower innervation 25 than an ordinary scar." Correct?</p>	<p>1 BY MS. BYARD: 2 Q. In terms of the number of nerves 3 present in tissue specimens density? 4 A. My expectation is that the scar 5 outside of the mesh would have about the same nerve 6 density as an irregular scar from after any 7 procedure. 8 In regards to innervation inside the 9 mesh, it will be somewhat lower than innervation 10 outside. But again, it's not clinically relevant 11 because the fact that it can ingrow, that's the 12 most important clinical question. 13 Q. And again, whether or not the 14 number of nerves that ingrow at the mesh is lower, 15 or whether it's statistically significantly lower, 16 is an open hypothesis at this point, true? 17 MR. ORENT: Objection. 18 THE WITNESS: I don't understand why we 19 are asking this. I mean, diagnostic process is -- 20 BY MS. BYARD: 21 Q. Sir, you don't need to agree with 22 my questions or why I'm asking them -- 23 MR. ORENT: Excuse me. He's answer -- 24 BY MS. BYARD: 25 Q. -- you just need to answer them.</p>
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<p>1 A. That's correct. 2 Q. Are those same findings true for 3 transvaginal mesh? 4 A. As I said, I mean, we -- to answer 5 these questions which are not relevant to 6 diagnostic process, you would have to compare 7 vaginal scar and the scar in around meshes. 8 Q. And that work has not been 9 completed to date, correct? 10 A. It has not been completed. 11 Q. Based on your observations to 12 date, do you expect that the innervation within a 13 mesh scar conglomerate is the same as within 14 vaginal scarring? 15 MR. ORENT: Can you repeat that or read 16 that one back? 17 REPORTER'S NOTE: Whereupon, the 18 pending question was read back as follows: 19 "Based on your observations to 20 date, do you expect that the 21 innervation within a mesh scare 22 conglomerate is the same within 23 vaginal scarring?" 24 MS. BYARD: Let me add to that. 25</p>	<p>1 MR. ORENT: Counsel, he's entitled to 2 finish. The way this process works is, you ask a 3 question, he answers. You don't cut him off midway 4 through his answer. 5 He's entitled to finish his answer, 6 then you can say whatever you want to say. 7 Doctor? 8 MS. BYARD: If you wouldn't mind, 9 Counsel, I think it would be productive for you to 10 provide some guidance to the witness about not 11 disputing why I'm asking a question. 12 MR. ORENT: Well, if he doesn't 13 understand, I think he's trying to understand where 14 this fits and so that he can answer the question. 15 I don't think he's trying to be difficult. 16 But, Doctor, if you could answer. 17 THE WITNESS: So my response is because 18 as far as I understand, we're talking about the 19 conclusions I derived based on my training, 20 knowledge, experience and the research included in 21 this one. 22 But it appears that you equate research 23 with the diagnostic process. Whatever I have done 24 in this study was in my head before I looked at 25 these specimens.</p>

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<p>1 BY MS. BYARD: 2 Q. And I'm trying to understand what 3 you've done on hernia repair and what you've done 4 on transvaginal mesh, okay? 5 A. Okay. 6 Q. And at this point, whether or not 7 the rate of nerve growth within transvaginal mesh 8 is less than the rate of nerve growth in the scar 9 surrounding the mesh is an open hypothesis, 10 correct? 11 MR. ORENT: Objection. 12 THE WITNESS: I can tell you that I 13 have some initial data, initial observations, but 14 it's not completed. Statistics is not completed 15 yet. 16 BY MS. BYARD: 17 Q. Okay. Thank you, sir. 18 Just to paraphrase, your findings with 19 respect to hernia repair was that both scar tissue 20 and scar tissue with mesh have a higher number of 21 nerves than virgin tissue, but that the difference 22 between the two groups was not statistically 23 significant? That's correct? 24 A. (Witness nods.) 25 Q. Now, if you look at the last</p>	<p>1 nerves." Correct? 2 A. That's correct. That's a 3 statement. It has no diagnostic conclusion or 4 anything else. 5 Q. Why did you include that language? 6 A. As I said, it's a description of 7 what we see, just for readers to understand what's 8 going on under the microscope. 9 Q. There are clinicians who 10 contributed to this paper, right? 11 A. Yes. 12 Q. Is it possible that to Dr. Bendavid 13 or to Dr. Koch, that whether these were similar in 14 size to ilioinguinal or iliohypogastric nerves had 15 some clinical bearing? 16 MR. ORENT: Objection. Calls for 17 speculation. 18 THE WITNESS: Had no clinical bearing. 19 BY MS. BYARD: 20 Q. Did you write this sentence or did 21 they? 22 MR. ORENT: Objection. 23 THE WITNESS: Oh, their manuscript was 24 edited, rewritten several times, several people 25 contributed.</p>
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<p>1 paragraph of the result section, which is just 2 before "discussion," you measured the nerves that 3 you saw, right? And by that I mean, you measured 4 their size? 5 A. Diameter, yes. 6 Q. For your evaluation of 7 transvaginal mesh specimens, you didn't measure the 8 diameter of the nerves that you detected, did you? 9 A. No. 10 Q. Part of what you were doing here 11 in your study with Dr. Bendavid, was trying to 12 correlate the size of the diameter of the nerves 13 that you found to whether they were similar, 14 dissimilar to inguinal or iliohypogastric nerves, 15 correct? 16 A. No. 17 Q. Tell me what you were trying to do 18 by measuring the diameter of the nerves then? 19 A. What I've just described, so the 20 readers would understand what I'm talking about. 21 Had no diagnostic significance. 22 Q. Well, you write: 23 "At 0.9 millimeters, the size 24 is not too dissimilar from that of 25 the ilioinguinal or iliohypogastric</p>	<p>1 I certainly contributed to each 2 sentence in one way or another. And I measured. 3 Nobody else could measure them. 4 BY MS. BYARD: 5 Q. Are you the one who supplied the 6 information about how the nerve sizes and diameter 7 compared to the size of known nerves in this 8 particular anatomy? 9 A. This is comparison of microscopic. 10 So I contributed by microscopic what I see, and 11 clinicians contributed to what they can see with 12 bare eyes without the microscope. 13 So the comparison is, roughly, for 14 surgeons to understand that the nerves we are 15 talking about can be as big as those they can see 16 by naked eye, but they can be much smaller that 17 they cannot see them. Therefore, they cannot avoid 18 them. 19 So basically it leads to readers to 20 understand that it's unavoidable to damage nerves 21 because they are so small that surgeons cannot see 22 them. 23 Q. And it was important for the 24 surgeons to talk about the type of nerves that 25 these were similar in size to, correct?</p>

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<p>1 MR. ORENT: Objection.</p> <p>2 THE WITNESS: I don't understand the</p> <p>3 question. What do you mean, "type of nerves"?</p> <p>4 BY MS. BYARD:</p> <p>5 Q. Well, it mentions specifically</p> <p>6 inguinal and iliohypogastric nerves, doesn't it?</p> <p>7 A. It's not a type of nerve. It's</p> <p>8 just a name of a larger branch.</p> <p>9 Q. Here, that name of those branches</p> <p>10 was important to specify?</p> <p>11 A. No.</p> <p>12 Q. It was completely superfluous?</p> <p>13 MR. ORENT: Objection. Argumentative.</p> <p>14 THE WITNESS: This is something which</p> <p>15 surgeons have readily -- are familiar with. It's a</p> <p>16 comparison, it's like a sliding scale, from 1 to</p> <p>17 10. So everybody within the span would know what</p> <p>18 we're talking about.</p> <p>19 BY MS. BYARD:</p> <p>20 Q. You're not a pain specialist,</p> <p>21 right?</p> <p>22 A. What do you mean "pain</p> <p>23 specialist"?</p> <p>24 Q. You don't treat and manage pelvic</p> <p>25 pain, do you?</p>	<p>1 "-- for a better understanding</p> <p>2 and application of anatomy, which</p> <p>3 easily transferred to tension free</p> <p>4 and laparoscopic repairs." Right?</p> <p>5 A. That's correct.</p> <p>6 Q. He writes:</p> <p>7 "Today's leitmotif in hernia</p> <p>8 surgery, to accompany the newer</p> <p>9 techniques, has been the extensive</p> <p>10 use of prosthetic materials."</p> <p>11 A. That's correct. That's epidemics</p> <p>12 now.</p> <p>13 Q. He used -- he says:</p> <p>14 "The philosophy of tension free</p> <p>15 repair which was made possible by</p> <p>16 the advent of synthetic materials</p> <p>17 was born in Marseille, France,</p> <p>18 fathered by Don Aquaviva in 1944,</p> <p>19 who used sagittate nylon sheets as</p> <p>20 an onlay over a defect which itself</p> <p>21 was left intact."</p> <p>22 Did I read that correctly?</p> <p>23 A. Yeah, you read it correctly.</p> <p>24 Q. He says:</p> <p>25 "The theme was re-visited by</p>
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<p>1 A. That's correct.</p> <p>2 Q. And you're not a neurologist?</p> <p>3 A. No, I am not a neurologist. You</p> <p>4 know what I am, I am pathologist.</p> <p>5 Q. And you're not a specialist in</p> <p>6 sexual health, correct?</p> <p>7 A. I just answered, I'm a</p> <p>8 pathologist.</p> <p>9 Q. Let's look at the discussion,</p> <p>10 please. You describe here that:</p> <p>11 "Indolent years of barber</p> <p>12 surgeons and anatomists and the</p> <p>13 beginning of a surgical renaissance."</p> <p>14 A. Yes, that was mostly Dr. Bendavid's</p> <p>15 contribution in this part.</p> <p>16 Q. I like his writing style.</p> <p>17 A. English is not my first language,</p> <p>18 so he writes better than me.</p> <p>19 Q. He writes:</p> <p>20 "A mini-revival took place with</p> <p>21 the rediscovery of --"</p> <p>22 And then he names some researchers and</p> <p>23 surgeons, right?</p> <p>24 A. That's correct.</p> <p>25 Q. And he writes:</p>	<p>1 Henri Fruchaud in 1956, who designed</p> <p>2 an operation also using nylon mesh</p> <p>3 in a manner which was antedated and</p> <p>4 precisely anticipated Francis Usher."</p> <p>5 Did I read that correctly?</p> <p>6 A. Yes, it appears you read it</p> <p>7 correctly.</p> <p>8 Q. "Usher provided the</p> <p>9 polyethylene, then polypropylene</p> <p>10 while reproducing Fruchaud's</p> <p>11 technique."</p> <p>12 Did I read that correctly?</p> <p>13 A. That's correct.</p> <p>14 Q. And then it continues that -- in</p> <p>15 this next full paragraph:</p> <p>16 "While several surgical</p> <p>17 techniques based on the principles</p> <p>18 of tension free repairs have been</p> <p>19 introduced in the last 30 years,</p> <p>20 polypropylene has become the</p> <p>21 dominant olefin utilized to that end."</p> <p>22 Did I read that correctly?</p> <p>23 A. That's correct.</p> <p>24 Q. It goes on to discuss the plastics</p> <p>25 industry producing Marlex; do you see that?</p>

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<p>1 A. Yes.</p> <p>2 Q. And a synthetic polymer discovered</p> <p>3 by J. Paul Hogan and Robert Banks of the Phillips</p> <p>4 Petroleum Company; do you see that?</p> <p>5 A. I lost you. Yes, I do see that.</p> <p>6 Q. And it says:</p> <p>7 "This discovery was made</p> <p>8 possible, thanks to the pioneering</p> <p>9 work and olefin chemistry by two</p> <p>10 Nobel Prize laureates 1963, Giulio</p> <p>11 Natta and Karl Ziegler."</p> <p>12 Do you see that?</p> <p>13 MR. ORENT: Objection.</p> <p>14 THE WITNESS: That's correct.</p> <p>15 BY MS. BYARD:</p> <p>16 Q. And then it goes on to describe</p> <p>17 there being an "unexpected and unpredicted</p> <p>18 prominence of pain" being the most common</p> <p>19 complication seen in mesh groin hernia repairs</p> <p>20 today, doesn't it?</p> <p>21 A. That's correct.</p> <p>22 Q. There's a discussion then about</p> <p>23 the industry development of lighter mesh, meshes</p> <p>24 with larger pores. Do you see that?</p> <p>25 A. Yes.</p>	<p>1 effect on tissue components."</p> <p>2 That's what's written here in your</p> <p>3 article, right?</p> <p>4 A. That's correct.</p> <p>5 Q. In this sentence you don't write</p> <p>6 that "tissue forces and chemical environment affect</p> <p>7 the mesh, which in turn has an effect on tissue</p> <p>8 components," do you?</p> <p>9 A. I have to see the sentence.</p> <p>10 MR. ORENT: Where is the sentence</p> <p>11 you're looking at, at this point?</p> <p>12 MS. BYARD: It's the first sentence</p> <p>13 preceding the discussion of Figure A and Figure B.</p> <p>14 THE WITNESS: Oh, this is like a</p> <p>15 feedback, this is a description. See, first is</p> <p>16 description that mesh affects, and then there is</p> <p>17 effect. And then there is a tissue which is</p> <p>18 affecting mesh, and but mesh can react back, so</p> <p>19 it's a complex sort of mechanism, which he has not</p> <p>20 studied yet.</p> <p>21 BY MS. BYARD:</p> <p>22 Q. And the stage that you're at here</p> <p>23 with hernia mesh, is understanding the tissue</p> <p>24 response to mesh, right?</p> <p>25 MR. ORENT: Objection.</p>
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<p>1 Q. And it essentially then describes</p> <p>2 this, this tradeoff in terms of collagen versus</p> <p>3 scar tissue ingrowth?</p> <p>4 A. You would have to read the</p> <p>5 sentence to me.</p> <p>6 Q. Sure. I just, I would hope to</p> <p>7 summarize. Essentially here, and correct me if I</p> <p>8 don't get this accurately, but essentially here you</p> <p>9 go on then to describe there being tradeoffs</p> <p>10 between wider pore -- lighter, larger pore meshes</p> <p>11 and smaller pore heavier weight meshes, correct?</p> <p>12 MR. ORENT: Objection.</p> <p>13 THE WITNESS: Yeah, we discussed that</p> <p>14 topic.</p> <p>15 BY MS. BYARD:</p> <p>16 Q. Sure. And then it says:</p> <p>17 "To understand the complex</p> <p>18 interaction between the olefins and</p> <p>19 biological tissues, their site of</p> <p>20 contact needs to be studied as a</p> <p>21 compartmentalized living tissue."</p> <p>22 A. That's correct.</p> <p>23 Q. "Additionally, tissue forces</p> <p>24 and chemical environments affect the</p> <p>25 mesh which in turn may have an</p>	<p>1 THE WITNESS: It's hard to actually</p> <p>2 differentiate what is mesh response to tissue, or</p> <p>3 tissue response to mesh, or what is mesh effect on</p> <p>4 the tissue, or what is tissue reaction to the mesh.</p> <p>5 I mean, it's interaction between mesh and tissue.</p> <p>6 But the intricate details of how this</p> <p>7 feeds back and catalyzes the process, I have not</p> <p>8 studied. Molecular mechanisms.</p> <p>9 BY MS. BYARD:</p> <p>10 Q. And the same is true for</p> <p>11 transvaginal mesh, true?</p> <p>12 MR. ORENT: Objection.</p> <p>13 THE WITNESS: That's correct. We can</p> <p>14 see the changes, what is the end result. But how</p> <p>15 this is all happening, and through what molecules,</p> <p>16 and this is not studied yet.</p> <p>17 BY MS. BYARD:</p> <p>18 Q. If you turn to page 808, please.</p> <p>19 A. Yes.</p> <p>20 Q. There is a discussion of you all</p> <p>21 setting up a mesh retrieval industry; do you see</p> <p>22 that?</p> <p>23 A. Yes.</p> <p>24 Q. And there being a protocol</p> <p>25 developed to address how contributions are made to</p>

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<p>1 the registry?</p> <p>2 A. Not exactly. Not how</p> <p>3 contributions are made. Dr. Bendavid through his</p> <p>4 contacts with colleagues, I mean, we started</p> <p>5 acquiring meshes just to build a library of</p> <p>6 specimens and examine them.</p> <p>7 Q. And then it says:</p> <p>8 "The next step will be the</p> <p>9 correlation of histology/pathology</p> <p>10 to the clinical presentation and</p> <p>11 severity of pain."</p> <p>12 A. Yes, that's correct.</p> <p>13 Q. What will your role be in this</p> <p>14 registry as far as you understand it?</p> <p>15 A. Not will be, I'm collecting</p> <p>16 specimens, I'm examining them.</p> <p>17 Q. Is your job to do the correlation</p> <p>18 of the histology pathology to the clinical</p> <p>19 presentation and severity of pain?</p> <p>20 A. Yes. I mean, I examine these</p> <p>21 specimens, There is history in them. Statistician</p> <p>22 is involved, so she's Dr. Lou is doing final</p> <p>23 statistical analysis. So statistical tests are</p> <p>24 applied by her. I do some statistics as well on</p> <p>25 the go and...</p>	<p>1 after I examine the specimens, then they are all</p> <p>2 put in all table, and then I can see the</p> <p>3 difference. But final statistical analysis is done</p> <p>4 by Dr. Lou, she does statistical tests.</p> <p>5 Q. So she's inputting the reasons for</p> <p>6 the excision, the clinical presentation, severity</p> <p>7 of the pain, she's inputting that with your</p> <p>8 histological findings?</p> <p>9 MR. ORENT: Objection.</p> <p>10 THE WITNESS: No. I'm receiving the</p> <p>11 specimens, I'm receiving initial information with</p> <p>12 the specimens.</p> <p>13 BY MS. BYARD:</p> <p>14 Q. What initial information?</p> <p>15 A. Reason for excision. I'm</p> <p>16 collecting age, gender, heterology, type of hernia,</p> <p>17 is it ventral, is it molecular, is it inguinal, I'm</p> <p>18 collecting all this clinical information with the</p> <p>19 specimen. It comes with specimens.</p> <p>20 Q. You conclude this paragraph by</p> <p>21 writing:</p> <p>22 "This is the duty of our</p> <p>23 profession. It is an oath" -- I'm</p> <p>24 sorry. I didn't start soon enough.</p> <p>25 Let me strike all that.</p>
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<p>1 Q. Who's the one evaluating the</p> <p>2 clinical presentation severity of pain for this</p> <p>3 registry, though?</p> <p>4 A. Mostly treating clinicians, so</p> <p>5 they provide -- I mean, at this stage what we</p> <p>6 manage to do is separate specimens according to</p> <p>7 reason for excision.</p> <p>8 So if pain is severe enough to cause</p> <p>9 excision without any other factors, or if pain was</p> <p>10 contributing factor as a reason for excision,</p> <p>11 assuming there is a combination of pain and hernia</p> <p>12 reoccurrence. Or, when the pain either didn't</p> <p>13 exist, or pain was low enough not to trigger</p> <p>14 incision, but mesh was either excised or sampled</p> <p>15 during revision of hernia reoccurrence. So that's</p> <p>16 where we ended up. I mean, so severity of pain</p> <p>17 became assessed as a reason for excision.</p> <p>18 Q. Okay. And that's done by the</p> <p>19 treating physician, correct?</p> <p>20 A. Yes.</p> <p>21 Q. And then the correlation between</p> <p>22 the pathology, what you find under microscopic</p> <p>23 examination, and this clinical presentation,</p> <p>24 severity of pain, who does that job?</p> <p>25 A. Initially, I see it. I mean,</p>	<p>1 You write:</p> <p>2 "While knowledge comes, let us</p> <p>3 translate it into wise application</p> <p>4 for which it was meant. This is the</p> <p>5 duty of our profession, it is an</p> <p>6 oath which we must honor proudly,</p> <p>7 disconnected from any notions of</p> <p>8 personal or commercial conflicts of</p> <p>9 interest."</p> <p>10 Do you agree with those statements?</p> <p>11 THE WITNESS: Yes, I do.</p> <p>12 BY MS. BYARD:</p> <p>13 Q. Here in the conclusion, and we had</p> <p>14 started to talk about this in the abstract, and so</p> <p>15 I wanted to return to it because you had pointed me</p> <p>16 that further on in the paper there would be</p> <p>17 discussion of it. So let's look at that.</p> <p>18 You write in the conclusion:</p> <p>19 "It is felt that the mechanism</p> <p>20 of pain associated with the use of</p> <p>21 mesh may similarly be due to micro</p> <p>22 entrapment and micro compartment</p> <p>23 types of syndromes through new nerve</p> <p>24 and vessel ingrowth within the mesh</p> <p>25 pores and other confining spaces</p>

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<p>1 with the concomitant edema, anoxia, 2 thrombi scarring, distortion, 3 migration and traction." 4 THE WITNESS: That is correct. 5 BY MS. BYARD: 6 Q. Do you see that? 7 A. That's correct. 8 Q. And is that what you were 9 referring me back to when we were talking about the 10 abstract? 11 A. Yes. 12 Q. Again, you say that: 13 "It is felt that the mechanism 14 of pain associated with the use of 15 mesh may be due to micro entrapment 16 and micro compartment." Right? 17 A. It says "similarly." 18 Q. So the analogy that you're making -- 19 A. So the mechanism is similarly. 20 Not that it's due or not due. The "may" implies a 21 similarity. 22 Q. Between what and what? 23 A. Yes. 24 Q. Between what and what? 25 A. Between compartment syndromes we</p>	<p>1 findings are there. 2 The balance of them, the details and 3 everything else, again, is not studied, it needs to 4 be further studied. But the findings, the 5 abnormality is visible, it's there. It's 6 100 percent there. 7 Q. So the -- you have observed and 8 established tissue abnormalities with hernia mesh, 9 right? 10 A. Yes. 11 Q. The step that hasn't been done yet 12 is understanding the mechanism by which those 13 tissue abnormalities lead to clinical complications 14 of pain? 15 A. Yes. Details of those mechanisms. 16 Q. And with respect to transvaginal 17 mesh, you're one step behind the study in that you 18 haven't yet done the statistical analysis of 19 relative rates of nerve ingrowth and 20 compartmentalization? 21 MR. ORENT: Objection. 22 THE WITNESS: What do you mean, one 23 step behind or in front? 24 BY MS. BYARD: 25 Q. Well, this study, this statistical</p>
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<p>1 already know, and these new compartment syndromes 2 we just discovered. 3 Q. So the mechanism of pain is 4 understood for compartment syndromes that are 5 already established? 6 A. Yes. 7 Q. And the mechanism of pain 8 associated with mesh may be similar for compartment 9 syndromes that you're beginning to study here? 10 A. Yeah. Mechanisms may not be 11 exactly the same, but may be similar. Likely to be 12 similar. 13 Q. Because at this point in the study 14 of hernia repair, those mechanisms of pain are not 15 established yet? 16 MR. ORENT: Objection. 17 BY MS. BYARD: 18 Q. Right? 19 A. Details of the mechanisms. So 20 when we observe the changes in the mesh, we clearly 21 saw that the scar tissue within the mesh is not 22 normal scar tissue. 23 So we knew that this tissue is 24 innervated, because we saw nerve ingrowth, and we 25 saw that it's not regular scar tissue. So the</p>	<p>1 analysis has been done. That statistical analysis 2 is yet to be done for transvaginal mesh? 3 MR. ORENT: Objection. 4 THE WITNESS: Are you asking in respect 5 of my opinions, or in respect of research and plans 6 for research? 7 BY MS. BYARD: 8 Q. I'm talking about the body of 9 scientific knowledge that's available. This was a 10 contribution to the understanding of the tissue 11 response to -- 12 A. Yes, I understand that. 13 Q. -- to hernia repair? 14 A. Are you asking if this analysis 15 was done to derive to the conclusions of this 16 report, or are we talking just hypotheticals 17 scientific questions. 18 MR. ORENT: Perhaps you can rephrase 19 the question. 20 BY MS. BYARD: 21 Q. Okay. Let me try and do that. 22 And I only am trying to say that with 23 respect to hernia repair, you understand you've 24 identified abnormalities in the tissue, in mesh? 25 A. Yes. And this exactly the same in</p>

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<p>1 transvaginal meshes.</p> <p>2 Q. You've identified tissue abnormalities?</p> <p>3 A. Even more. I found more in</p> <p>4 transvaginal meshes than in what is the hernia</p> <p>5 meshes.</p> <p>6 Q. Okay.</p> <p>7 A. So in this respect, this part is</p> <p>8 step ahead from this.</p> <p>9 Q. Well, in terms of the degree of</p> <p>10 abnormalities, you're saying?</p> <p>11 MR. ORENT: Objection.</p> <p>12 THE WITNESS: Yes.</p> <p>13 BY MS. BYARD:</p> <p>14 Q. Okay.</p> <p>15 A. There are way more findings in</p> <p>16 transvaginal meshes than in hernia meshes. This</p> <p>17 study was specifically focused on nerve ingrowth.</p> <p>18 What we found there, abnormality in the scar tissue</p> <p>19 was observation only, sort of, on the way we did</p> <p>20 the study.</p> <p>21 This was done later, and there are more</p> <p>22 findings, more abnormalities in transvaginal</p> <p>23 meshes.</p> <p>24 Q. You've gotten to the level,</p> <p>25 though, of doing a statistical analysis to quantify</p>	<p>1 Exhibit 1196?</p> <p>2 A. It's not scientific rigor or</p> <p>3 scientific work. This is diagnostic work; this is</p> <p>4 scientific work. This is research; this is</p> <p>5 diagnostic. When I see abnormal, I state. Here is</p> <p>6 a specific question.</p> <p>7 I mean, you're just trying to mix</p> <p>8 things which are not -- not the same.</p> <p>9 Q. But you've made conclusions in</p> <p>10 your report on transvaginal mesh that are broader</p> <p>11 than the conclusions that you've reached in this</p> <p>12 study?</p> <p>13 A. Yes.</p> <p>14 MR. ORENT: Objection.</p> <p>15 BY MS. BYARD:</p> <p>16 Q. Right?</p> <p>17 MR. ORENT: Point out a particular</p> <p>18 question if you have one.</p> <p>19 THE WITNESS: This part -- okay.</p> <p>20 BY MS. BYARD:</p> <p>21 Q. Go ahead.</p> <p>22 A. No.</p> <p>23 MR. ORENT: Wait for a proper question.</p> <p>24 MS. BYARD: Are you instructing him not</p> <p>25 to answer that question?</p>
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<p>1 the tissue abnormalities for hernia mesh?</p> <p>2 A. Yes.</p> <p>3 Q. And you haven't reached that stage</p> <p>4 yet for transvaginal mesh?</p> <p>5 MR. ORENT: Objection.</p> <p>6 THE WITNESS: Well, it's present.</p> <p>7 Whatever is present here is 100 percent. I see</p> <p>8 abnormality, it's stated there.</p> <p>9 These rate and frequencies and</p> <p>10 everything else, only makes sense for scientific</p> <p>11 questions.</p> <p>12 But for detection of abnormality in the</p> <p>13 specific specimen or specific patient, is</p> <p>14 100 percent. I see it or I don't see it. If I</p> <p>15 don't see it, I don't describe it.</p> <p>16 BY MS. BYARD:</p> <p>17 Q. Okay.</p> <p>18 A. We are talking about this specific</p> <p>19 reports which are produced for each specific</p> <p>20 patient, and this was done for actually one</p> <p>21 specific scientific question.</p> <p>22 Q. And I guess I'm operating off the</p> <p>23 assumption that you've applied the same level of</p> <p>24 scientific rigor, that you did in this publication</p> <p>25 that you did with Dr. Bendavid, that you did for</p>	<p>1 MR. ORENT: No. I think there's no</p> <p>2 question pending that's intelligible.</p> <p>3 All you said is, "there are some</p> <p>4 opinions in here that are broader than those." But</p> <p>5 you haven't identified any opinions for him to</p> <p>6 address specifically.</p> <p>7 BY MS. BYARD:</p> <p>8 Q. Do you agree with what I've said, sir?</p> <p>9 MR. ORENT: Objection.</p> <p>10 THE WITNESS: Opinions or -- I'm a</p> <p>11 little bit confused. I mean --</p> <p>12 BY MS. BYARD:</p> <p>13 Q. Okay. That's okay, I can rephrase it.</p> <p>14 So here in your study with Dr. Bendavid</p> <p>15 on hernia mesh, you've described what the</p> <p>16 mechanisms of pain may be for the relationship</p> <p>17 between tissue abnormalities and clinical</p> <p>18 complications, right?</p> <p>19 MR. ORENT: Objection.</p> <p>20 THE WITNESS: Details of this</p> <p>21 mechanisms, the connection. I mean, I see -- so,</p> <p>22 we know that there is reason for excision, we know</p> <p>23 that there are pathological findings. What we see</p> <p>24 in the microscope is not normal, it's abnormal.</p> <p>25 We know that the mesh caused clinical</p>

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<p>1 symptom, had to be excised. How this all happened</p> <p>2 in small details, up to very small molecules of how</p> <p>3 they interact, is not known.</p> <p>4 But we know the effect, and we know the</p> <p>5 pathological findings behind it. But the details</p> <p>6 of this connection, these small sort of details are</p> <p>7 not clear.</p> <p>8 Some of it is, as mentioned, are</p> <p>9 similar to more study there is, like toothache I</p> <p>10 said, or heart attack. But again, this is in</p> <p>11 pieces.</p> <p>12 BY MS. BYARD:</p> <p>13 Q. So, for instance, you could have a</p> <p>14 nerve that was grown into scar tissue, that doesn't</p> <p>15 cause so much pain that the scar tissue has to be</p> <p>16 excised, right?</p> <p>17 MR. ORENT: Objection.</p> <p>18 THE WITNESS: This can happen. I mean,</p> <p>19 it may or may not. People are different.</p> <p>20 BY MS. BYARD:</p> <p>21 Q. And so you can look at a slide of</p> <p>22 mesh, with scar tissue, and see a nerve grown into</p> <p>23 it, and you can't predict whether that patient had</p> <p>24 pain, can you?</p> <p>25 A. I can say that there is</p>	<p>1 innervation of the tissue, the tissue would not</p> <p>2 sense any pain. So this is, this is predictable.</p> <p>3 If we have inflammation, we know that</p> <p>4 there will be lower threshold for pain. This has</p> <p>5 been studied extensively in other areas of</p> <p>6 inflammation. Inflammation is always associated</p> <p>7 with lower threshold of pain. What doesn't hurt in</p> <p>8 normal tissue, may hurt in inflamed tissue.</p> <p>9 So inflammation is high enough, it will</p> <p>10 cause pain on its own. Inflammation itself will be</p> <p>11 enough to cause pain, but it may not be enough, and</p> <p>12 then it will need the extra stimulus such as edema.</p> <p>13 This is very complex interaction.</p> <p>14 BY MS. BYARD:</p> <p>15 Q. And so -- but those specific</p> <p>16 mechanisms of how this relationship between nerve</p> <p>17 ingrowth or vascular ingrowth, scar tissue,</p> <p>18 inflammation, and whether or not that will cause or</p> <p>19 predict pain in a patient is not yet described?</p> <p>20 MR. ORENT: Objection.</p> <p>21 THE WITNESS: It is described in other</p> <p>22 areas. It's a general knowledge of what they</p> <p>23 accumulated. I mean, does inflamed knee hurt? I</p> <p>24 mean, what do you think? It's not just described,</p> <p>25 it is a general knowledge. Something is inflamed,</p>
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<p>1 probability, there is mechanism for pain in that</p> <p>2 specific, if patient have or didn't have pain, this</p> <p>3 may depend on different circumstances. It may not</p> <p>4 hurt today, but it has probability it may hurt</p> <p>5 tomorrow.</p> <p>6 So this would be, again, complex. And</p> <p>7 it's not just for a nerve. If there is a nerve</p> <p>8 ingrown in the tissue, it means that the tissue is</p> <p>9 alive. It can sense pain. So this is the</p> <p>10 baseline. Then, pain can occur at any time there.</p> <p>11 You add extra stimuli for pain, damage to the</p> <p>12 tissue, inflammation, edema -- the more you add,</p> <p>13 the probability goes higher and higher. But,</p> <p>14 again, you may have just a nerve ingrowth and it</p> <p>15 gets tugged, and you have mechanism of pain right</p> <p>16 away. So this is so complex, and a variable</p> <p>17 between people, we cannot apply a specific --</p> <p>18 now I'm --</p> <p>19 Q. It's not predictable?</p> <p>20 MR. ORENT: Objection.</p> <p>21 THE WITNESS: No, this is not true.</p> <p>22 It's predictable. If you have nerve ingrowth, you</p> <p>23 have baseline for pain development.</p> <p>24 So, once you have innervation of the</p> <p>25 tissue, pain can develop. If you don't have</p>	<p>1 it may hurt.</p> <p>2 BY MS. BYARD:</p> <p>3 Q. Do you know whether 100 percent of</p> <p>4 patients with edema present in their mesh and the</p> <p>5 tissues surrounding their mesh will feel pain?</p> <p>6 A. What's percentage of those who</p> <p>7 have edema or don't have edema? I don't know exact</p> <p>8 percentage. And I don't think it matters, because</p> <p>9 it might be multiple mechanisms.</p> <p>10 So their pathological findings which</p> <p>11 are normal, and the degree of their contribution to</p> <p>12 pain development is hard to predict because it's so</p> <p>13 complex.</p> <p>14 Q. And not yet known?</p> <p>15 MR. ORENT: Objection.</p> <p>16 THE WITNESS: What do you mean, "not</p> <p>17 yet known?" We know that inflamed tissue hurts.</p> <p>18 BY MS. BYARD:</p> <p>19 Q. But the rates at which it will</p> <p>20 occur -- for instance, with edema, you can't tell</p> <p>21 me the rates at which pain will occur or --</p> <p>22 A. The main question is, it can</p> <p>23 happen. If it happens in the patient, you know why</p> <p>24 this is happening. Assuming, if an area in the</p> <p>25 body hurts, and you take a biopsy, and you see</p>

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<p>1 inflammation in there, but you don't see anything 2 else, what would be your logical conclusion, why 3 did it hurt? Because it was inflamed and you don't 4 see anything else. 5 The same with meshes. Meshes hurt; 6 they come out. There is no tumor in it, there is 7 no informal carcinoma, but there is nerve ingrowth, 8 there is mesh, there is scarring. 9 Therefore, the only reason for it to 10 hurt is mesh-related changes. But the degree of 11 contribution of how much inflammation contributed, 12 how much edema contributed, is difficult to 13 predict. It has been studied in other areas. It 14 was not studied in specific details in meshes. 15 Q. Thank you. 16 Let me check the time. 17 MS. BYARD: Do you guys have steam for 18 another article before we break for lunch? 19 THE WITNESS: I have to go to the 20 washroom. 21 MR. ORENT: Why don't we take five. 22 THE VIDEOGRAPHER: Off the record at 23 12:24 p.m. 24 -- RECESS AT 12:24 -- 25 -- UPON RESUMING AT 12:40 --</p>	<p>1 many points of contact with other agencies, not 2 everything is disclosed, or authors decide for that 3 specific study there is no conflict of interest. 4 It's more up to the discretion of the author. 5 Q. But all things being equal, the 6 better course would be if the bias might affect the 7 subject of study, to disclose that conflict of 8 interest, right? 9 A. Yes -- 10 MR. ORENT: Objection. 11 THE WITNESS: -- it's the best sort of 12 scientific practice. Not practice, but -- 13 BY MS. BYARD: 14 Q. It's important for authors in the 15 scientific and medical community, to disclose 16 conflict of interest? 17 MR. ORENT: Objection. 18 THE WITNESS: It's important for 19 readers to know if there's potential conflict of 20 interest, yes. 21 BY MS. BYARD: 22 Q. So, at this point, you have been 23 deposed, I think we had the number at around seven 24 or eight times in litigation where you've testified 25 as an expert against mesh manufacturers, right?</p>
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<p>1 THE VIDEOGRAPHER: We're back on the 2 record at 12:40 p.m. 3 BY MS. BYARD: 4 Q. Doctor, would you agree with me 5 that it's important to keep bias out of scientific 6 research? 7 MR. ORENT: Objection. 8 THE WITNESS: Yes. Yes, it is 9 important. 10 BY MS. BYARD: 11 Q. And you would agree that bias in 12 the form of industry influence, is bad for science, 13 right? 14 MR. ORENT: Objection. 15 THE WITNESS: Yes. 16 BY MS. BYARD: 17 Q. So if a study was supported or 18 funded by industry, the author would disclose that, 19 right? 20 A. Yes, usually all conflicts are 21 disclosed. 22 Q. Or should, in your view -- 23 A. Should, yes. 24 Q. -- disclose that? 25 A. Yes, yes. Sometimes there's so</p>	<p>1 A. That's correct. 2 Q. And you've never once testified 3 for a defendant manufacturer in a medical device 4 case, correct? 5 A. You mean like crossing sides? No. 6 Q. You never testified on behalf of a 7 mesh manufacturer in that company's defence? 8 MR. ORENT: Objection. 9 THE WITNESS: No. 10 BY MS. BYARD: 11 Q. And since 2012, early 2013, all of 12 the work that you've done on mesh as an expert in 13 litigation has been for plaintiffs, right? 14 MR. ORENT: Objection. 15 THE WITNESS: That's correct. It just 16 happened that all findings I had, they were 17 supporting plaintiffs' claims. 18 BY MS. BYARD: 19 Q. Those findings were made while you 20 were being paid for your work for the plaintiffs' 21 though, correct? 22 MR. ORENT: Objection. 23 THE WITNESS: I'm just paid for my 24 time. 25</p>

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<p>1 BY MS. BYARD:</p> <p>2 Q. You're paid by plaintiffs for your</p> <p>3 time?</p> <p>4 MR. ORENT: Objection.</p> <p>5 THE WITNESS: Sometimes, like today, I</p> <p>6 don't know, maybe you will pay for that, I mean --</p> <p>7 I actually sometimes don't know where the money</p> <p>8 comes from. There's so many people involved.</p> <p>9 BY MS. BYARD:</p> <p>10 Q. And while there's nothing -- I</p> <p>11 guess returning to my question about disclosures.</p> <p>12 There's nothing that prevents an author from</p> <p>13 providing disclosures of conflicts of interest if</p> <p>14 the author feels that's important, right?</p> <p>15 A. For full articles, it's usually a</p> <p>16 requirement, but sometimes for abstracts, I mean,</p> <p>17 then you don't know where to squeeze it, if there</p> <p>18 is no line when you submit it. So for abstracts</p> <p>19 there may be no space to put this disclosure.</p> <p>20 So if I don't have that space, while</p> <p>21 submitting an abstract, I insert a slide disclosing</p> <p>22 that I've been consulting for medical-legal cases.</p> <p>23 I don't remember single time when I never -- when I</p> <p>24 have not disclosed it.</p> <p>25 Either way, I will find a way how to</p>	<p>1 A. Payment is not the only bias, I</p> <p>2 will mean only other bias. I mean it's just what</p> <p>3 you consider. But people may be biased by</p> <p>4 something else.</p> <p>5 EXHIBIT NO. 1198: International</p> <p>6 Scholarly and Scientific Research &</p> <p>7 Innovation, 2014, Publication entitled,</p> <p>8 "Pathology of Explanted Transvaginal</p> <p>9 Meshes," by Dr. V. Iakovlev,</p> <p>10 Dr. E. T. Carey and Dr. J. Steege.</p> <p>11 BY MS. BYARD:</p> <p>12 Q. Doctor, do you recognize</p> <p>13 Exhibit 1198?</p> <p>14 A. Yes, it's a paper I co-authored.</p> <p>15 Q. Dr. Erin Teeter Carey is an expert</p> <p>16 whose time is paid for by the Plaintiffs in the</p> <p>17 mesh litigation; isn't she?</p> <p>18 A. Yes.</p> <p>19 Q. And Dr. John Steege is a paid</p> <p>20 Plaintiffs' expert too, right?</p> <p>21 A. Yes.</p> <p>22 Q. And you were in fact introduced to</p> <p>23 Dr. Erin Teeter Carey and Dr. John Steege by</p> <p>24 Margaret Thomson, a lawyer for the Plaintiffs,</p> <p>25 right?</p>
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<p>1 disclose it. Either during presentation or during</p> <p>2 abstract submission, or any other way.</p> <p>3 Q. Were all the publications that you</p> <p>4 have authored on transvaginal mesh published in</p> <p>5 2014?</p> <p>6 A. Yes.</p> <p>7 Q. And the articles that you've</p> <p>8 authored on transvaginal mesh have direct bearing</p> <p>9 on the reasons for your opinions in the lawsuit,</p> <p>10 right?</p> <p>11 MR. ORENT: Objection to form.</p> <p>12 THE WITNESS: It's kind of -- I</p> <p>13 wouldn't word it like this. I considered all the</p> <p>14 knowledge extracted during, doing this research</p> <p>15 project in formulating my opinions in these</p> <p>16 reports, yes.</p> <p>17 BY MS. BYARD:</p> <p>18 Q. Well, and in fact, in all of the</p> <p>19 publications that you authored, that came out this</p> <p>20 year, you included information that you identified</p> <p>21 during your work as a paid expert for the</p> <p>22 Plaintiffs, correct?</p> <p>23 A. Yes. As I said, I mean, I</p> <p>24 disclose it every time I can.</p> <p>25 Q. Let's mark 1198.</p>	<p>1 A. Yeah. I think first contact was</p> <p>2 during a conference call, and I think Dr. Thomson</p> <p>3 was either participant or organizer of that call.</p> <p>4 Q. She was acting as a lawyer during</p> <p>5 that conference call, correct?</p> <p>6 MR. ORENT: Objection. At this point,</p> <p>7 I'm going to instruct the witness not to answer to</p> <p>8 the extent that there are -- that this was as part</p> <p>9 of a case consultation or work.</p> <p>10 You can answer to the extent that you</p> <p>11 had any conversations with the four of those people</p> <p>12 related to non-litigation work.</p> <p>13 BY MS. BYARD:</p> <p>14 Q. Dr. Margaret Thomson was on the</p> <p>15 call in her capacity as a lawyer, not in her</p> <p>16 capacity as a medical doctor, right?</p> <p>17 MR. ORENT: Objection.</p> <p>18 THE WITNESS: I don't know. She's a</p> <p>19 doctor and a lawyer, I mean, what capacity she's</p> <p>20 serving in...</p> <p>21 BY MS. BYARD:</p> <p>22 Q. You were paid for your time on</p> <p>23 these conference calls by Plaintiffs' lawyers or</p> <p>24 their firms, right?</p> <p>25 MR. ORENT: Objection.</p>

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<p>1 THE WITNESS: I don't think I</p> <p>2 specifically charged for all these conference calls</p> <p>3 or contacts. It depends, I mean, it's...</p> <p>4 BY MS. BYARD:</p> <p>5 Q. You weren't there in conjunction</p> <p>6 with your work as an anatomical pathologist at</p> <p>7 St. Michael's, though, right?</p> <p>8 MR. ORENT: I'm going to now instruct</p> <p>9 the witness -- this is all covered by Rule 26</p> <p>10 privileges. So if you want to ask questions</p> <p>11 related to his work on these papers, I'll let him</p> <p>12 answer anything related to the papers. But if</p> <p>13 you're asking about his specific relationship with</p> <p>14 Plaintiffs, Plaintiffs' experts and trial strategy</p> <p>15 meetings, I'm going to specifically instruct him</p> <p>16 not to answer.</p> <p>17 BY MS. BYARD:</p> <p>18 Q. Are you going to follow Counsel's</p> <p>19 instruction?</p> <p>20 A. As I said initially, I had first</p> <p>21 contact --</p> <p>22 MR. ORENT: I only want you to answer</p> <p>23 as to the extent that you can answer without</p> <p>24 revealing any trial strategy meetings you may have</p> <p>25 attended, or anything related to your consultation</p>	<p>1 significance? I didn't hear you.</p> <p>2 A. The degree of statistical</p> <p>3 significance is not either assessed, or is not</p> <p>4 95 percent, or there are other factors which</p> <p>5 introduce the degree of unknown factors.</p> <p>6 Q. Okay. So here, for whether or not</p> <p>7 the pathological examination explains mechanisms of</p> <p>8 complications resulting in product excision, which</p> <p>9 one of those factual scenarios that you described</p> <p>10 applied? Is that, is it that there was not an</p> <p>11 assessment of statistical significance? Was it</p> <p>12 that there was other confounding factors, or that</p> <p>13 the degree of significance was not statistically --</p> <p>14 the degree of difference was not statistically</p> <p>15 significant?</p> <p>16 MR. ORENT: Objection.</p> <p>17 THE WITNESS: No, neither. Because</p> <p>18 this states a hypothesis, so before we started, we</p> <p>19 examined and we had a hypothesis made. So it was --</p> <p>20 this statement describes state of the research</p> <p>21 project before the research project.</p> <p>22 BY MS. BYARD:</p> <p>23 Q. Okay. So let's look at the</p> <p>24 discussion on page 508. The last paragraph of the</p> <p>25 discussion ends after discussion of nerve</p>
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<p>1 related to Plaintiffs in this litigation.</p> <p>2 THE WITNESS: Okay.</p> <p>3 BY MS. BYARD:</p> <p>4 Q. Let's take a look at the abstract</p> <p>5 of this published article conceived in a conference</p> <p>6 call with Plaintiffs' counsel.</p> <p>7 MR. ORENT: And I'm going move to</p> <p>8 strike that comment as without foundation.</p> <p>9 BY MS. BYARD:</p> <p>10 Q. It says:</p> <p>11 "We aimed to perform a thorough</p> <p>12 pathological examination of</p> <p>13 explanted POP meshes and describe</p> <p>14 findings that may explain mechanisms</p> <p>15 of complications resulting in</p> <p>16 product excision."</p> <p>17 Do you see that?</p> <p>18 THE WITNESS: Yes, I do.</p> <p>19 BY MS. BYARD:</p> <p>20 Q. And again, we see that word "may"</p> <p>21 there, don't we?</p> <p>22 A. Yes. This is a commonly accepted</p> <p>23 term, which we use when the degree of significance</p> <p>24 is not 95 percent.</p> <p>25 Q. So the degree of confidence or</p>	<p>1 entrapment and compression, stretching, edema,</p> <p>2 ischemia.</p> <p>3 It says: "The roles of these</p> <p>4 mechanisms need to be further studied," doesn't it?</p> <p>5 A. Yes. Exactly which part of -- can</p> <p>6 you point?</p> <p>7 Q. Yes, yes. Excuse me. The last</p> <p>8 sentence of the first full paragraph under</p> <p>9 "Discussion".</p> <p>10 A. Yes, I can see it.</p> <p>11 Q. And I read that correctly, right?</p> <p>12 A. "The roles of these mechanisms</p> <p>13 need to be further studied." Yes, that is correct.</p> <p>14 Q. The conclusory sentences of the</p> <p>15 next paragraph read:</p> <p>16 "Polypropylene degradation may</p> <p>17 play a role in the continuous</p> <p>18 inflammatory response mesh hardening</p> <p>19 and light deformations."</p> <p>20 Did I read that correctly?</p> <p>21 THE WITNESS: That's correct.</p> <p>22 BY MS. BYARD:</p> <p>23 Q. And it says:</p> <p>24 "Also, chemical products of</p> <p>25 degradation need to be studied for</p>

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<p>1 their composition and effect on the 2 tissue." 3 Did I read that correctly? 4 A. That is correct. 5 Q. And then in the last sentence of 6 the last paragraph of the discussion, it says: 7 "We believe that these 8 specimens contain information of the 9 mechanisms of complications and 10 further study may help guide future 11 development of treatment modalities." 12 Did I read that correctly? 13 A. That's correct. 14 Q. And it says: 15 "These are previously 16 unreported findings." 17 In the first sentence of that 18 paragraph, right? 19 A. Some of the findings were 20 previously unreported, yes, that's correct. 21 Q. And again, was this language "may" 22 used here because the statistical -- a 23 statistically significant difference was not 24 assessed between controlled samples in the study? 25 MR. ORENT: Objection.</p>	<p>1 ingrowth, then degradation itself, how much of one 2 of those contribute and so on. It's, again, degree 3 of uncertainty. 4 Also, degradation is continuous 5 process, so it will build up over the years, in the 6 beginning so -- there's a degree of uncertainty 7 between all of those. I mean, what we know, it 8 degrades, and with what we know, it hardens. So 9 these are the two points which we know for sure. 10 But the degree of connection and the 11 complex interaction between these factors is not 12 studied to details. Therefore, in scientific 13 literature the word "may" is used. 14 Q. What this discussion doesn't say 15 is that the tissue findings that you have observed 16 in transvaginal mesh causes pain through the 17 mechanisms that you've described? 18 A. Where does it say? 19 Q. Well, I'm saying, nowhere does 20 this discussion conclude that, does it? 21 A. It wasn't the purpose of the 22 study. Just read the title: "Pathology of 23 Explanted Transvaginal Meshes." 24 It was a descriptive study describing 25 the findings.</p>
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<p>1 THE WITNESS: You have to point exact 2 sentence. Which, which "may"? 3 BY MS. BYARD: 4 Q. "Polypropylene degradation may 5 play a role in the continuous 6 inflammatory response, mesh 7 hardening and late deformations." 8 A. Yes, so let me see. I have to 9 read the whole paragraph. 10 Q. Okay. 11 A. (Witness reviews document). 12 Yeah, this is a combination. See, 13 inflammatory response, mesh hardening and late 14 deformations. 15 This is observations which we have. 16 But the degree of connection between degradation 17 and each of this is different. 18 For example, if we go to continuous 19 inflammatory response, we would have to study exact 20 chemicals which are produced during degradation. 21 And how these chemicals may modify inflammatory 22 response and other thing, this is unknown. 23 Therefore, it introduces a degree of uncertainty. 24 Mesh hardening -- there will be 25 different mechanisms for mesh hardening, scar</p>	<p>1 Q. Okay. And, again, this article 2 doesn't even go so far as to say that mesh could 3 cause pain through the -- through these tissue 4 response mechanisms that you've described? 5 MR. ORENT: Objection. 6 THE WITNESS: Again, this was not the 7 purpose of this study. Purpose of this study, if 8 you read the abstract is, meshes cause 9 complications. This triggers excision, and they 10 have not been studied as to find reasons and 11 mechanisms of the complications. 12 So the purpose of this was to study and 13 see what is pathological in those specimens, 14 abnormal. And then these abnormalities can be 15 described and documented. 16 And then the next step would be to 17 split specimens according to specific complications 18 and see statistically what each of those specific 19 pathology co findings contribute, and what's the 20 interaction between them. So it's study details of 21 all this. 22 BY MS. BYARD: 23 Q. And that second step that you've 24 described wasn't done here? 25 A. No.</p>

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<p>1 Q. And it hasn't been done by you?</p> <p>2 A. I'm in the process of doing,</p> <p>3 studying the small details of these things.</p> <p>4 Because for each specific finding,</p> <p>5 there is a degree of knowledge we have in pathology</p> <p>6 and overall in general. I mean, even for common</p> <p>7 person, if vessel is obstructed, you know, there</p> <p>8 will be no bleed going through it. It doesn't need</p> <p>9 further studying.</p> <p>10 But how does it get obstructed? Is it</p> <p>11 because there is a slowing down of the blood in</p> <p>12 there? Or because it's chemical issues affecting --</p> <p>13 a chemical product of degradation, which is</p> <p>14 affecting blood or blood vessel, that makes it</p> <p>15 clot.</p> <p>16 All these details will have to be</p> <p>17 studied. I'm surprised it wasn't for 50 years,</p> <p>18 because the findings are there.</p> <p>19 Q. Right, and that's a fair point. I</p> <p>20 mean, for 50 years, pathologists have looked at</p> <p>21 polypropylene mesh, and no one has seen what you</p> <p>22 have seen and reported here, which is</p> <p>23 degradation --</p> <p>24 MR. ORENT: Objection.</p> <p>25 BY MS. BYARD:</p>	<p>1 Q. Okay. We can do that in a second.</p> <p>2 Looking back here at the "Materials and</p> <p>3 Methods Section," if you would, Doctor.</p> <p>4 A. Yes.</p> <p>5 Q. You write:</p> <p>6 "In total, 24 specimens of</p> <p>7 St. Michael's Hospital patients and</p> <p>8 external consultation cases from</p> <p>9 litigation processes have been</p> <p>10 analyzed."</p> <p>11 Did I read that correctly?</p> <p>12 A. That's correct.</p> <p>13 Q. What does, "external consultation</p> <p>14 cases from litigation processes" mean?</p> <p>15 A. Litigation cases.</p> <p>16 Q. These lawsuits we're here to talk</p> <p>17 about today, as well as the ones involving other</p> <p>18 manufacturers?</p> <p>19 A. Yes.</p> <p>20 Q. Why is the number here 24, when</p> <p>21 we -- in your report we have 120?</p> <p>22 A. For that specific number -- first</p> <p>23 of all, let's see if it was -- see, it was limited</p> <p>24 to POP first. It was limited to those -- I could</p> <p>25 get exact information at that point, it was entered</p>
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<p>1 Q. -- right?</p> <p>2 A. Have they been looking at all</p> <p>3 meshes? Have they been looking to answer the</p> <p>4 questions of complications? I mean...</p> <p>5 Q. My question is simpler: No one</p> <p>6 else has reported having seen what you see.</p> <p>7 MR. ORENT: Objection. That misstates</p> <p>8 the record.</p> <p>9 THE WITNESS: That's not true. I mean,</p> <p>10 there are papers which are stating some of the</p> <p>11 findings.</p> <p>12 Like polypropylene degradation, it was</p> <p>13 first described in the '70s. There's a degree,</p> <p>14 there are different methods. Sometimes it's not</p> <p>15 the primary purpose of the study, but in</p> <p>16 combination, these findings were mentioned in many</p> <p>17 papers.</p> <p>18 BY MS. BYARD:</p> <p>19 Q. By pathologists?</p> <p>20 A. Pathologists -- you mean scientist</p> <p>21 pathologists or diagnostic pathologists?</p> <p>22 Q. Either.</p> <p>23 A. I don't know. We would have to</p> <p>24 look at each paper and see what's the credentials</p> <p>25 included, and what exactly is described there.</p>	<p>1 in the spreadsheet. So at that point, I had</p> <p>2 verified reliable data, which was on the</p> <p>3 spreadsheet for those 24 only POPs.</p> <p>4 Again, this was started much earlier</p> <p>5 before 120. The paper became published maybe half</p> <p>6 a year after the study was pretty much done.</p> <p>7 Q. So at the time that you submitted</p> <p>8 this report for publication, you only had the</p> <p>9 completed verified data set or 24 POP specimens; is</p> <p>10 that right?</p> <p>11 MR. ORENT: Objection.</p> <p>12 THE WITNESS: With all information, I</p> <p>13 would need to include it in the study, yes. It my</p> <p>14 be for some samples I didn't have exact information</p> <p>15 if it was POP or sling or something else.</p> <p>16 BY MS. BYARD:</p> <p>17 Q. If we were going to consider the</p> <p>18 120 specimens that are in your report for inclusion</p> <p>19 in this study, how many would meet the criteria?</p> <p>20 And let's say for purposes of this</p> <p>21 evaluation, that the study is not limited to POP,</p> <p>22 but includes SUI product?</p> <p>23 MR. ORENT: I just want to object to</p> <p>24 your use of the term, "120 cases included in your</p> <p>25 report."</p>

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<p>1 I want to make clear, what Dr. Iakovlev 2 is talking about on page 2 of his report is his 3 experience, and then he goes on to talk about his 4 education and training. 5 His opinions are based on his 6 experience, education and training; but are not 7 based specifically on any one sample or samples. 8 And I think you're confusing him. It's not a 9 report on 120 cases that he's offered here. 10 MS. BYARD: Counsel, again, the 11 speaking objections are not -- 12 MR. ORENT: That's not an objection. 13 That's a clarification for the record. 14 MS. BYARD: I'm asking him about his 15 data set, which are specimens, which are what my 16 questions are directed to. 17 THE WITNESS: I can answer that 18 question. 19 All findings described in this paper 20 could be seen in those 120 or larger number of 21 specimen. I see them over and over again. 22 BY MS. BYARD: 23 Q. But you don't have -- you don't 24 have this completed data set that you had on these 25 24 specimens on all 120?</p>	<p>1 lightweight mesh, how many samples of each were 2 included in these 24. You have examples of what 3 area focally of the mesh was filled with loose 4 connective tissue. You have statistics on the 5 number of specimens that showed neural ganglia 6 involvement. 7 I'm just trying to understand if all of 8 those same data points have been obtained and exist 9 in the spreadsheet, or however you keep it, for the 10 120 specimens that are referenced in your report? 11 MR. ORENT: Objection. 12 THE WITNESS: This data is obtained for 13 all specimens which are completed, which excision 14 is completed with surgical pathology report. 15 As you saw, as I mentioned, the 16 surgical pathology report includes all of this 17 because I examine all specimens according to 18 standardized protocol. 19 So all of the findings which are 20 described are even more since then are recorded, 21 assessed, either they're there or they're not 22 there. 23 How many of those have been completed, 24 likely close to 100, but I haven't updated it 25 recently because of an avalanche of work recently.</p>
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<p>1 A. We'll deal in data set. It's not 2 a data set, it's a descriptive study which is 3 describe what findings we could find. There is no 4 statistics in it, if you can see -- 5 I mean, there is statistics of 6 frequencies in this specific 24. 7 Q. Right. 8 A. But it's not a comparison between 9 what happens in those who experience these type of 10 complication and the other one. 11 I mean, as I said, if we take generally 12 the purpose of this study, pathology of explanted 13 transvaginal meshes so -- and it was specifically 14 focused on POP devices. 15 If I take all of the POP devices I 16 examined, there will be no -- all of these findings 17 can be seen there. And all of them can be 18 included, and if you're trying to ask me if I 19 selected them specifically, no. I can expect these 20 findings in any POP devices. 21 Q. Actually, what I'm trying to 22 understand, Doctor, is whether the data that you 23 had to complete this study. So, for instance, here 24 you have descriptions of the fragment size. You 25 have descriptions of the heavyweight versus</p>	<p>1 BY MS. BYARD: 2 Q. Here under "Results," you mention 3 that: 4 "Available clinical records 5 indicated mucosal exposure as a 6 reason for excision in 67 percent of 7 cases --" do you see that? 8 A. Yes. 9 Q. And: 10 "Pain in 56 percent of cases, 11 and both, in 33 percent of cases." 12 A. Correct. 13 Q. You also say that the product -- 14 these 24 specimens, include products from three 15 different manufacturers; do you see that? 16 A. Yes, I do. 17 Q. Which were the three 18 manufacturers? 19 A. The earliest I received was AMS, 20 and then you, and then probably Ethicon. 21 Q. Okay. So the study includes 22 Boston Scientific devices? 23 A. By the time of this study, likely. 24 Q. Is there something you can check 25 to confirm that for me?</p>

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<p>1 A. Yes, I should be able to do that.</p> <p>2 MS. BYARD: Okay. We need to go off</p> <p>3 the record to change the tape.</p> <p>4 THE VIDEOGRAPHER: This marks the end</p> <p>5 of media number two in the deposition of</p> <p>6 Dr. Vladimir Iakovlev.</p> <p>7 We are going off the record at</p> <p>8 1:08 p.m.</p> <p>9 -- OFF THE RECORD DISCUSSION --</p> <p>10 THE VIDEOGRAPHER: Here begins media</p> <p>11 number three in the deposition of Dr. Vladimir</p> <p>12 Iakovlev.</p> <p>13 We're back on the record at 1:09 p.m.</p> <p>14 Go ahead, Counsel.</p> <p>15 MS. BYARD: Thank you.</p> <p>16 BY MS. BYARD:</p> <p>17 Q. What did you mean by -- excuse me</p> <p>18 if I said this -- actually, let me withdraw that.</p> <p>19 Here, if we turn to "Disclosures", Doctor.</p> <p>20 This reads:</p> <p>21 "Authors provided medical-legal</p> <p>22 consultations on the subject."</p> <p>23 A. Yes.</p> <p>24 Q. At the time you published this</p> <p>25 article, you were working as a paid expert for</p>	<p>1 THE WITNESS: That's correct.</p> <p>2 BY MS. BYARD:</p> <p>3 Q. You were a paid expert for the</p> <p>4 Plaintiffs in mesh litigation before you published</p> <p>5 this report, right?</p> <p>6 A. Yes.</p> <p>7 Q. And you continue to be one today?</p> <p>8 A. Yes, I am.</p> <p>9 Q. That relationship hasn't stopped</p> <p>10 since it began?</p> <p>11 MR. ORENT: Objection.</p> <p>12 THE WITNESS: No, but you made it sound</p> <p>13 as if it's my full-time job.</p> <p>14 BY MS. BYARD:</p> <p>15 Q. I didn't mean to imply that. What</p> <p>16 percentage of it is your income?</p> <p>17 A. As I said, I mean, I haven't</p> <p>18 completed billing, and I haven't -- last year it</p> <p>19 was less than 10 percent.</p> <p>20 Q. And this year do you have an</p> <p>21 estimate of what percentage litigation consulting</p> <p>22 work for Plaintiffs will make of your overall</p> <p>23 income?</p> <p>24 A. Probably more than last year,</p> <p>25 likely more than 10 percent. But how much more, I</p>
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<p>1 Plaintiffs, right?</p> <p>2 MR. ORENT: Objection.</p> <p>3 THE WITNESS: No, I was working as a</p> <p>4 pathologist at St. Michael's Hospital. But I</p> <p>5 provided consultations, and I was paid for time I</p> <p>6 spent for consultations.</p> <p>7 BY MS. BYARD:</p> <p>8 Q. At the time that you published</p> <p>9 this report, you were still acting as a retained</p> <p>10 expert for Plaintiffs, right?</p> <p>11 MR. ORENT: Objection.</p> <p>12 THE WITNESS: What do you mean</p> <p>13 "acting"? I mean, my main job is pathologist at</p> <p>14 St. Michael's Hospital and assistant professor at</p> <p>15 the University of Toronto. I do provide</p> <p>16 medical-legal consultations when asked.</p> <p>17 BY MS. BYARD:</p> <p>18 Q. Your relationship, your consulting</p> <p>19 relationship with Plaintiffs' counsel, hadn't ended</p> <p>20 by the time this report was published, right?</p> <p>21 MR. ORENT: Objection.</p> <p>22 THE WITNESS: That's correct.</p> <p>23 BY MS. BYARD:</p> <p>24 Q. It was ongoing?</p> <p>25 MR. ORENT: Objection.</p>	<p>1 don't know. Less than 50 percent, anywhere between</p> <p>2 10 to 50 percent.</p> <p>3 Q. Here, though, in your disclosure</p> <p>4 it doesn't say which side your consulting work was</p> <p>5 on, does it?</p> <p>6 MR. ORENT: Objection.</p> <p>7 THE WITNESS: No. But should I bias</p> <p>8 readers, or just tell them that I may be biased?</p> <p>9 Because if I start disclosing then, further</p> <p>10 details, I introduce extra bias.</p> <p>11 BY MS. BYARD:</p> <p>12 Q. Well, it could cause some authors</p> <p>13 to discredit your -- some readers to discredit your</p> <p>14 work, because they know that your work was for one</p> <p>15 side versus the other; is that what you're saying?</p> <p>16 MR. ORENT: Objection.</p> <p>17 THE WITNESS: It's up to readers to</p> <p>18 decide if there is a bias in the paper. I just</p> <p>19 provide them this information that I may have a</p> <p>20 bias. Which way and how -- I mean, I can be</p> <p>21 criticizing specific type of mesh and working for</p> <p>22 another manufacturer, who is trying to sell not</p> <p>23 polypropylene mesh. I mean, there might be</p> <p>24 multiple biases.</p> <p>25 But it clearly states that I can be</p>

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<p>1 biased in this paper, and I disclose it.</p> <p>2 BY MS. BYARD:</p> <p>3 Q. It sounds like this is something</p> <p>4 you've thought about this before?</p> <p>5 A. What do you mean?</p> <p>6 Q. Did you make a conscious decision</p> <p>7 about whether or not to include that it was for one</p> <p>8 side versus the other that you were doing this</p> <p>9 consulting work?</p> <p>10 MR. ORENT: Objection.</p> <p>11 THE WITNESS: I always approach</p> <p>12 everything trying to be as neutral as possible, and</p> <p>13 give neutral information. I mean, it's always in</p> <p>14 my head.</p> <p>15 BY MS. BYARD:</p> <p>16 Q. So did you have a discussion with</p> <p>17 Dr. Carey and Dr. Steege about whether you should</p> <p>18 put which side your consulting work was on?</p> <p>19 A. No, I don't remember if we</p> <p>20 discussed the specifics. I mean, usually, it's</p> <p>21 disclosed conflict of interest, and people describe</p> <p>22 them as the way they think is most appropriate.</p> <p>23 Sometimes journal has specific requirements, how</p> <p>24 you describe it.</p> <p>25 Q. So, for instance, if a study -- a</p>	<p>1 Q. Peers, just picking up this</p> <p>2 article, this article alone, wouldn't know that you</p> <p>3 have testified for plaintiffs against mesh</p> <p>4 manufacturers in seven depositions and at two</p> <p>5 trials, would they?</p> <p>6 MR. ORENT: Now you're misrepresenting</p> <p>7 the timeline and facts of this case and being</p> <p>8 argumentative.</p> <p>9 THE WITNESS: I just don't understand</p> <p>10 where you would see that somebody would list all</p> <p>11 the depositions and everything else in disclosure.</p> <p>12 Disclosure, as I said, if it's funded,</p> <p>13 usually the funding agencies provide it.</p> <p>14 If there are other conflicts of</p> <p>15 interest, they just provide it through best sort of</p> <p>16 neutral, or shortest way, or depending on the</p> <p>17 paper.</p> <p>18 This paper wasn't funded by anyone. I</p> <p>19 received the specimens from different sources, and</p> <p>20 we analyzed it, and there was no additional work to</p> <p>21 what usually pathology laboratory does.</p> <p>22 BY MS. BYARD:</p> <p>23 Q. So the words "for plaintiffs" does</p> <p>24 not appear in this disclosure, right?</p> <p>25 MR. ORENT: Objection.</p>
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<p>1 clinical study, let's say, was funded by Boston</p> <p>2 Scientific, it would indicate that it was funded by</p> <p>3 Boston Scientific, if the author was following,</p> <p>4 what you've described as the best practices, right?</p> <p>5 MR. ORENT: Objection.</p> <p>6 THE WITNESS: If a study is funded by a</p> <p>7 specific agency, there might be a specific</p> <p>8 question.</p> <p>9 When you submit it, it might be just a</p> <p>10 drop-down menu. Was it funded by someone; by whom?</p> <p>11 Then you have to disclose it.</p> <p>12 If it's a free text, what you disclose,</p> <p>13 you can say that funding came from this, this and</p> <p>14 that agency. And then readers can decide if it can</p> <p>15 have a bearing on the conclusions.</p> <p>16 BY MS. BYARD:</p> <p>17 Q. How common is it for you to see a</p> <p>18 disclosure that says, "this research was funded"</p> <p>19 without any indication as who the funding was from?</p> <p>20 A. What do you mean "funded"?</p> <p>21 Usually when it's funded it says a grant or</p> <p>22 something else agency.</p> <p>23 Q. The disclosure tells you who</p> <p>24 funded?</p> <p>25 A. Yes. But this study wasn't funded.</p>	<p>1 THE WITNESS: No. And, essentially, it</p> <p>2 was part of the purpose not to bias it in this way.</p> <p>3 As I said, there might be multiple</p> <p>4 biases. Plaintiff, not plaintiff, the manufacturer</p> <p>5 can be presenting different type of biases.</p> <p>6 Plaintiffs have claims that it caused</p> <p>7 damage. But at the same time, there might be</p> <p>8 another manufacturer which can introduce bias. As</p> <p>9 I said, there's two types of devices on the market</p> <p>10 and so forth. There might be multiple biases.</p> <p>11 BY MS. BYARD:</p> <p>12 Q. As a reader, someone could not</p> <p>13 tell which type of multiple biases that are</p> <p>14 possible could have influenced your writing on the</p> <p>15 subject?</p> <p>16 MR. ORENT: Objection.</p> <p>17 THE WITNESS: That's not the point.</p> <p>18 The point is that to disclose that there might be</p> <p>19 bias. And -- if you are funded by an agency,</p> <p>20 assuming. So, you assume that that agency has --</p> <p>21 either doesn't or has some control of what is being</p> <p>22 published and what is not being published.</p> <p>23 But it's not included in the statement;</p> <p>24 it just states what's the agencies. It's up to</p> <p>25 readers to think if it could have an affect on the</p>

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<p>1 researcher or couldn't.</p> <p>2 So this is how it is done. It is</p> <p>3 disclosed to the most neutral way, and then it's up</p> <p>4 to readers to see if the paper, paper itself,</p> <p>5 contains any information that it could have been</p> <p>6 biased.</p> <p>7 BY MS. BYARD:</p> <p>8 Q. And part of how you evaluate that</p> <p>9 is by knowing who funded the study?</p> <p>10 MR. ORENT: Objection.</p> <p>11 THE WITNESS: No, no. Not exactly.</p> <p>12 BY MS. BYARD:</p> <p>13 Q. Part of the way that you do that</p> <p>14 is knowing who prior consulting work was for?</p> <p>15 MR. ORENT: Objection.</p> <p>16 THE WITNESS: I would say not who</p> <p>17 funded the study, but if the funding agency could</p> <p>18 have an effect or control on the researchers,</p> <p>19 that's the most important question.</p> <p>20 I mean, most of the clinical studies or</p> <p>21 other are funded, because it's such an expensive --</p> <p>22 but then it's up to readers to see if funding</p> <p>23 agency could control, could have an effect. It may</p> <p>24 be not direct.</p> <p>25 I mean, like you focusing on</p>	<p>1 THE WITNESS: Have you ever seen --</p> <p>2 BY MS. BYARD:</p> <p>3 Q. Does the word appear there,</p> <p>4 Doctor?</p> <p>5 A. No, it's not --</p> <p>6 MR. ORENT: Counsel, you're not</p> <p>7 entitled to badger the witness. He's answered your</p> <p>8 question four times. You're trying to clearly get</p> <p>9 your bullet point, you can read the article just as</p> <p>10 well as any of us.</p> <p>11 The Rules of Civil Procedure do not</p> <p>12 permit badgering of the witness, so move on.</p> <p>13 MS. BYARD: It's my deposition and I'm</p> <p>14 entitled to get answers to my questions.</p> <p>15 BY MS. BYARD:</p> <p>16 Q. My question is simply this, Doctor:</p> <p>17 Under the disclosure, in your study</p> <p>18 with Dr. Carey and Dr. Steege, it says, "authors</p> <p>19 provided medical-legal consultations on this</p> <p>20 subject." It does not say "for plaintiffs," does</p> <p>21 it?</p> <p>22 A. No, it does not --</p> <p>23 MR. ORENT: Objection.</p> <p>24 THE WITNESS: -- state. I could have</p> <p>25 been providing for both Plaintiffs and</p>
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<p>1 manufacturers. But there are some non-for-profit</p> <p>2 organizations which are funding with grants and</p> <p>3 everything else, and there is a competition to get</p> <p>4 these grants and so forth. So you might be biased</p> <p>5 to produce better results in order to renew a grant</p> <p>6 and so forth.</p> <p>7 So this is a different bias. It might</p> <p>8 be even stronger than just financial bias. It's</p> <p>9 the same financial bias, because you are acquiring</p> <p>10 grants from there. Again, it's up to the readers</p> <p>11 to decide if that specific funding agency could</p> <p>12 have an effect.</p> <p>13 Medical-legal consultation means that</p> <p>14 somebody provided opinion and was paid. So this</p> <p>15 can create a bias, and it's up to readers, again,</p> <p>16 go and see if there is any indication that there</p> <p>17 was a bias. And I provided bias -- that, that</p> <p>18 possibility.</p> <p>19 BY MS. BYARD:</p> <p>20 Q. Let's see what we can agree on,</p> <p>21 because you've said a lot on this.</p> <p>22 All I want to know is whether the word</p> <p>23 "for plaintiffs" appears in this sentence?</p> <p>24 MR. ORENT: Objection. That's been</p> <p>25 asked and answered.</p>	<p>1 manufacturers.</p> <p>2 BY MS. BYARD:</p> <p>3 Q. As a reader, I would have no way</p> <p>4 of knowing which side your testimony had been paid</p> <p>5 for by reading your article?</p> <p>6 MR. ORENT: Objection.</p> <p>7 THE WITNESS: You shouldn't have to</p> <p>8 know. You should be able to go through the paper</p> <p>9 and try to find clues if there was a bias. Because</p> <p>10 that's the whole point of critical appraisal in the</p> <p>11 literature.</p> <p>12 If somebody tells you from the</p> <p>13 beginning, that this study is biased because it was</p> <p>14 paid and so forth, would you read this article?</p> <p>15 BY MS. BYARD:</p> <p>16 Q. Is that part of the reason why you</p> <p>17 didn't disclose which side you were on?</p> <p>18 A. No, I'm just saying that I never</p> <p>19 seen a single paper where the disclosure was</p> <p>20 formulated the way you're trying to introduce.</p> <p>21 I have never seen when it states that</p> <p>22 somebody was consulted on side of plaintiff. Maybe</p> <p>23 they exist, but I've never seen it.</p> <p>24 Q. Have you seen disclosures where it</p> <p>25 says, "doctor so and so provided consulting for</p>

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<p>1 such and such company"?</p> <p>2 MR. ORENT: Objection.</p> <p>3 THE WITNESS: Usually it's financial</p> <p>4 disclosure. "This funding was sponsored or funded</p> <p>5 in part by this manufacturer" or something like</p> <p>6 this.</p> <p>7 I don't remember specifically wording</p> <p>8 like you've just said. Usually they describe</p> <p>9 funding agency or manufacturer in terms of funding</p> <p>10 source.</p> <p>11 EXHIBIT NO. 1199: Abstract entitled,</p> <p>12 "Pathological Findings of Transvaginal</p> <p>13 Polypropylene Slings Explanted for Late</p> <p>14 Complications: Mesh is Not Inert," by</p> <p>15 Dr. V. Iakovlev, Dr. G. Mekel and Dr.</p> <p>16 J. Blaivas</p> <p>17 BY MS. BYARD:</p> <p>18 Q. I'm handing you Exhibit 1199.</p> <p>19 And this is another publication of</p> <p>20 yours from this year, right, Doctor?</p> <p>21 A. That's correct.</p> <p>22 Q. And this is an article that you</p> <p>23 published with doctor -- I'm sorry -- an abstract</p> <p>24 that you published with Dr. Mekel and Dr. Blaivas,</p> <p>25 right?</p>	<p>1 here.</p> <p>2 A. Coauthors. Yes, you read it</p> <p>3 correct.</p> <p>4 Q. Here there is a discussion of,</p> <p>5 again, looking at specimens. This time of</p> <p>6 transvaginal slings; do you see that?</p> <p>7 A. Yes, this was limited to slings.</p> <p>8 Q. How many specimens were included</p> <p>9 in this write-up? I thought I saw 63 in Table 1.</p> <p>10 A. Yes. So a total number was 63,</p> <p>11 18 were retropubic and 45 were transobturator.</p> <p>12 Q. Here, for the 63 studies, you used</p> <p>13 scar tissue from non-mesh excisions as a reference</p> <p>14 control?</p> <p>15 A. Just general understanding, how it</p> <p>16 looks and what are the pathological findings, yes.</p> <p>17 Q. There wasn't any sort of objective</p> <p>18 measuring of the number of nerves, or the number of</p> <p>19 blood vessels like we saw in your hernia mesh study</p> <p>20 with Dr. Bendavid, right?</p> <p>21 A. No. In this case, scar tissue was</p> <p>22 used more for a reference for inflammation, for</p> <p>23 foreign body reaction and other mesh-related</p> <p>24 changes.</p> <p>25 Q. I wanted to understand the</p>
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<p>1 A. That's correct.</p> <p>2 Q. And Dr. Blaivas is a paid</p> <p>3 Plaintiffs' expert, too, right?</p> <p>4 A. I know that he gave his opinion to</p> <p>5 some cases.</p> <p>6 Q. For the Plaintiffs, correct?</p> <p>7 A. I don't know if only for the</p> <p>8 Plaintiffs. For those I know for Plaintiffs, it</p> <p>9 could have been giving opinion for manufacturers of</p> <p>10 this.</p> <p>11 Q. So of the cases that you're aware</p> <p>12 of, he testified for the Plaintiffs?</p> <p>13 A. Yes.</p> <p>14 Q. You write:</p> <p>15 "Over the last decade</p> <p>16 polypropylene mesh slings have</p> <p>17 become the most commonly performed</p> <p>18 operation for stress incontinence."</p> <p>19 Correct?</p> <p>20 A. That's correct. Did I write --</p> <p>21 where did I say -- (Witness reviews documents.)</p> <p>22 In part. It could be part of my</p> <p>23 wording and part of other --</p> <p>24 BY MS. BYARD:</p> <p>25 Q. That's the language that appears</p>	<p>1 sentence two, three lines in, under "Interpretation</p> <p>2 of Results" where you write:</p> <p>3 "In contrast, mature scar</p> <p>4 tissue after non-mesh surgeries does</p> <p>5 not show inflammation."</p> <p>6 Do you see that?</p> <p>7 A. So can you point where you --</p> <p>8 Q. Sure. Underneath "Interpretation</p> <p>9 of Results," the third sentence in.</p> <p>10 MR. ORENT: Paragraph 2.</p> <p>11 THE WITNESS: "In contrast, mature scar</p> <p>12 after non-mesh surgeries does not show</p> <p>13 inflammation." Yes, that's correct.</p> <p>14 BY MS. BYARD:</p> <p>15 Q. What does "mature scar tissue"</p> <p>16 mean?</p> <p>17 A. Mature scar tissue. Scar tissue</p> <p>18 is mature.</p> <p>19 Q. Is there a point in time when scar</p> <p>20 tissue shows evidence of inflammation?</p> <p>21 A. When it's really early in its</p> <p>22 development. I mean, the first initial reaction to</p> <p>23 injury, the initiating event of scarring is</p> <p>24 associated first with the formation. First</p> <p>25 neutrophils come, and then macrophages and then --</p>

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<p>1 Q. And we don't really need to go 2 into all that, because I do understand that from 3 your deposition before. I appreciate that, thank 4 you, Doctor. 5 What I'm trying to understand is when 6 in time you will stop seeing inflammation in the 7 development of scar tissue? 8 A. Sometime after few weeks of 9 healing. 10 Q. How long will it take for nerves 11 to begin to ingrow in scar tissue? 12 A. Also happens within first few 13 weeks of healing. 14 Q. First few weeks -- are we talking 15 one to four weeks, or are we talking one to 16 six weeks? What's the window that's accepted? 17 A. It's very variable. It depends on 18 individuals, conditions, repetitive injury. And 19 all this process are continuing from about day 20 three to anywhere six, eight weeks, maybe longer. 21 If there is continuous injury, it may repeat itself 22 during years. 23 Q. So if a patient, for instance, 24 complained of immediate postoperative pain, would 25 it be fair to say that nerve ingrowth in mesh</p>	<p>1 There are multiple differences between 2 a scar without mesh and a scar with mesh. 3 BY MS. BYARD: 4 Q. In this discussion where you say, 5 "scar tissue from non-mesh excisions were used as 6 reference controls," are you referring to the scar 7 tissue that you used from the abdominal wall in the 8 Dr. Bendavid study, or were you specifically 9 referencing scar tissue from vaginal mesh 10 excisions? 11 A. In this case, specifically for 12 vaginal mesh. I mean, they were not grouped 13 together, but either with the specimens, sometimes 14 I received just scar tissue without mesh outside. 15 Sometimes it's just a scar excision and surgeon 16 identifies it as a scar excision. Or sometimes we 17 receive it in the course of some surgeries in 18 St. Michael's Hospital, so I visually know what it 19 looks like. 20 Q. And then you go on to write that: 21 "Surprisingly, easily visible 22 in the microscope, it has been 23 overlooked for 50 years." 24 And there you're describing what you've 25 coined as a term, "degradation bark"; right?</p>
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<p>1 structures could not be the source of that pain, 2 because nerves could not yet appear growing within 3 the mesh structure? 4 A. Yes, that's correct. 5 Q. Okay. And here you talk about 6 potential sources of pain, you write: 7 "Within these mini compartments, 8 the innervated tissue is exposed to 9 potential sources of pain such as 10 compression, stretching, 11 inflammation, ischemia, etcetera." 12 A. That's correct. 13 Q. But you would agree these 14 potential sources of pain are also present in scar 15 tissue where there is compression, stretching of 16 the scar tissue, inflammation in the scar tissue, 17 ischemia, etcetera, wouldn't you? 18 A. No. 19 MR. ORENT: Objection. 20 THE WITNESS: No, I wouldn't agree. 21 There is no inflammation, there is no edema, scar 22 tissue doesn't show conditional edema. Scar is 23 pliable, it can change over time. So if there is 24 shrinking, it will slowly change because it's 25 native tissue.</p>	<p>1 A. Yes, that's correct. The 2 degradation layer was not described as it appears 3 in the light microscope. 4 Q. And that's what I was getting at 5 earlier. On the one hand you told me degradation 6 of polypropylene has been described since the 7 1970s. And then here, in this abstract that you 8 publish with Dr. Blaivas, you say it's been 9 overlooked for 50 years? I was trying to reconcile 10 that. 11 A. Well, it's clear. This states 12 about microscopic appearance and the cross-sections 13 in a light microscope, and I'm talking about 14 detection of degradation by other means, either 15 scanning electron microscopy or mechanical testing. 16 So this is specifically for microscopic appearance 17 and light microscope. 18 Q. So if you were going to complete 19 the following sentence: "I was the first 20 pathologist to observe..." what? 21 MR. ORENT: Objection to form. 22 THE WITNESS: I don't know if I was 23 first one. 24 BY MS. BYARD: 25 Q. You were the first one to report</p>

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<p>1 findings on degradation of -- degradation bark 2 under polarized light in microscopic observation? 3 MR. ORENT: Objection. 4 THE WITNESS: I'm the first one who is 5 describing light microscopy features of 6 polypropylene degradation. So that would be a full 7 definition. To my knowledge, I am the first one. 8 BY MS. BYARD: 9 Q. To your knowledge, nobody else has 10 done it besides you up until this point? 11 A. Nobody published. 12 Q. You continue: 13 "From mesh exposure an 14 important finding was that sling 15 edges rotated or curled towards the 16 surface at the exposure sites." 17 Tell me what you meant by that. 18 THE WITNESS: Sometimes when a reason 19 for excision is mesh exposure, the mesh, if you can 20 see the mesh is rotated -- if this is the mucosal 21 surface, I can see it's rotated. I can see the 22 curl. If it is a big enough piece and well 23 oriented then I can see it. 24 BY MS. BYARD: 25 Q. Based on your observations to</p>	<p>1 BY MS. BYARD: 2 Q. So you could design an experiment 3 where you looked at incidences of exposure, and 4 whether or not there was curling, and also a 5 control sample where there's curling but not 6 exposure, right? 7 A. I can tell you for sure, if I see 8 the edge rotated towards, the mesh was curled 9 100 percent. 10 Some cases I see curling completely 11 outside of the exposure -- if there's no exposure 12 surgically described. So, based on these two 13 observations, I can state if curling occurs close 14 to the surface, the edge is prone to be exposed. 15 Q. You can't say that exposures occur 16 at a statistically significant rate with curled 17 mesh edges? 18 A. But -- 19 Q. Over non-curved mesh edges? 20 A. What do you compare it with? You 21 have to -- clinical experiment would be, curled 22 meshes are placed right under the mucosa, and then 23 the rate of exposure is measured. Can you do that? 24 You can't. 25 Every time I see it's curled at the</p>
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<p>1 date, are you able to say whether the exposure of 2 the mesh causes the curling or whether the curling 3 causes the exposure? 4 A. Sometimes it's not curled, but 5 it's still exposed. So I make a conclusion, 6 curling which makes it exposed. 7 Q. Sometimes it's exposed but not 8 curling, though, right? 9 A. Yes. 10 Q. Okay. So something other than the 11 curling causes the exposure in those instances? 12 A. There might be different 13 mechanisms, but one of the mechanisms is curling. 14 Q. Okay. 15 A. Most of the curled part is inside 16 the exposure site. It's only the tip which is 17 exposed. 18 Q. And you haven't done a statistical 19 analysis in order to say whether or not this edge 20 curling phenomena occurs with a statistically -- at 21 a statistically significant rate with exposures to 22 conclude there's a causal relationship, right? 23 MR. ORENT: Objection. 24 THE WITNESS: I don't understand what 25 would you compare with -- I mean, what -- I mean --</p>	<p>1 mucosa, it's exposed; 100 percent, as I said. If 2 it's not at the mucosa, it cannot be exposed 3 because it's too far. You cannot design experiment 4 in this retrospective way. 5 Q. Well, there isn't an edge if it's 6 not exposed though? 7 A. No, I don't -- so if you want to 8 assess the rate of exposure, which would occur due 9 to curling, you would have to place flat meshes 10 under the surface and then curled meshes under the 11 surface, observe them for five, six years, and then 12 calculate the rate. That would be start answering 13 your question. 14 Right now what I see, if it's curled 15 and it's at mucosa, it's 100 percent exposed. But 16 as I said, sometimes it's flat and it's still 17 exposed. Or, in orientation I cannot assess if 18 it's curled, not curled. It's just poor 19 orientations. 20 Q. You conclude with a message: 21 "Polypropylene degradation 22 needs to be studied further for its 23 role in inflammation, mesh hardening 24 and late deformation, as well as for 25 the properties of chemical</p>

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<p>1 degradation products."</p> <p>2 Did I read that correctly?</p> <p>3 A. That is correct.</p> <p>4 Q. And here again, what this</p> <p>5 conclusion reinforces, is that there's a need for a</p> <p>6 further study to understand the details of the</p> <p>7 mechanisms of actions of the relationships between</p> <p>8 degradation and inflammation, as well as mesh</p> <p>9 hardening, and whether any chemical degradation</p> <p>10 products are produced or what they are, right?</p> <p>11 MR. ORENT: Objection.</p> <p>12 THE WITNESS: That's correct. Because</p> <p>13 what we know? We know that some patients present</p> <p>14 with complaints six or eight years after the</p> <p>15 insertion.</p> <p>16 So the only thing which changes over</p> <p>17 time is the degree of degradation. So degradation</p> <p>18 layer or bark is getting thicker, so it's inflamed</p> <p>19 and so forth.</p> <p>20 So from what we know now, the only late</p> <p>21 factor which happens around the mesh or to the mesh</p> <p>22 is degradation. So those changes which occur later</p> <p>23 on, will have more -- larger component of</p> <p>24 degradation within the mechanisms of this.</p> <p>25 But how exactly it occurs, then again,</p>	<p>1 consulting in Exhibit 1199, right?</p> <p>2 A. Well, this is --</p> <p>3 MR. ORENT: Objection.</p> <p>4 THE WITNESS: -- clearly disclosed.</p> <p>5 BY MS. BYARD:</p> <p>6 Q. Where?</p> <p>7 A. "Some external consultations sent</p> <p>8 for litigation purposes" -- see, again, this was a</p> <p>9 very structured way of submitting abstract. I</p> <p>10 didn't have much flexibility to put in. I had a</p> <p>11 drop-down menu for funding only.</p> <p>12 See if it's -- see, funding, subject,</p> <p>13 ethics committee and everything else, I could enter</p> <p>14 only specific amount of information in the</p> <p>15 drop-down menu. So I tried my best to disclose as</p> <p>16 much as I can.</p> <p>17 Q. So your testimony is that for</p> <p>18 1198 and 1199, there was a free text field you</p> <p>19 could type in?</p> <p>20 MR. ORENT: Objection.</p> <p>21 THE WITNESS: To a certain degree -- I</p> <p>22 don't remember exactly now but I mean it was --</p> <p>23 which one?</p> <p>24 BY MS. BYARD:</p> <p>25 Q. The one we looked at before where</p>
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<p>1 it needs to be studied. Or, if I observe a bark or</p> <p>2 degradation layer, I can see the cracks in it. I</p> <p>3 know that they're internal forces which shrink it.</p> <p>4 But how much of that, how all these forces work, I</p> <p>5 mean, it all needs to be studied.</p> <p>6 BY MS. BYARD:</p> <p>7 Q. You also write here one sentence</p> <p>8 before this:</p> <p>9 "The compartmentalizing nature</p> <p>10 of the meshes and nerve ingrowth</p> <p>11 might create a background for the</p> <p>12 pain mechanisms."</p> <p>13 Do you see that? It's just one</p> <p>14 sentence before the one we just read.</p> <p>15 A. Can you point on your copy?</p> <p>16 Q. Yes, here.</p> <p>17 A. Yes, that's correct.</p> <p>18 Q. Again, you've used this word</p> <p>19 "may"?</p> <p>20 A. Again, because all these --</p> <p>21 Q. That's my only question. That's</p> <p>22 the word that you've used, right?</p> <p>23 A. Well, it's written.</p> <p>24 Q. And there's no disclosure of any</p> <p>25 conflicts of interest related to medical-legal</p>	<p>1 you published with Dr. Carey?</p> <p>2 A. This one was free text, just</p> <p>3 submitted paper. It was just, um, paragraph</p> <p>4 disclosures, this one was more restricted.</p> <p>5 Q. And so -- but you typed in the</p> <p>6 words, "Some specimens were received as external</p> <p>7 consultations sent for litigation purposes."</p> <p>8 A. That's correct. Yes, I did it.</p> <p>9 Q. And again, the word "for</p> <p>10 Plaintiffs" does not appear here, does it?</p> <p>11 A. No. But, as I said, we discussed</p> <p>12 it before.</p> <p>13 MS. BYARD: We need to take a break now</p> <p>14 for everyone.</p> <p>15 THE WITNESS: So it's 20 to 2:00. Do</p> <p>16 we take a break and then come back? I can still go</p> <p>17 on for another hour or so.</p> <p>18 MS. BYARD: Do you mind if we discuss</p> <p>19 this off the record?</p> <p>20 MR. ORENT: Yes, sure.</p> <p>21 THE VIDEOGRAPHER: Going off the record</p> <p>22 at 1:40 p.m.</p> <p>23 -- RECESS AT 1:40 p.m.</p> <p>24 -- UPON RESUMING AT 2:16 --</p> <p>25 THE VIDEOGRAPHER: We're back on the</p>

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<p>1 record at 2:16 p.m. 2 BY MS. BYARD: 3 Q. Doctor, I'm handing you 4 Exhibit 1200. I'll ask if you recognize that? 5 A. Yes, I do. 6 Q. This was an abstract that you 7 published this year with the -- let me start over. 8 This was an abstract that was published this year? 9 A. Yes, that's correct. 10 Q. The title is, "Explanted Surgical 11 Meshes: What Pathologists and Industry Failed to 12 Do for Over 50 Years"; is that right? 13 A. For 50 years. 14 Q. Thank you. Under "Objective" you 15 write, three sentences in: 16 "Estimated millions of devices 17 have been excised over the years, 18 however, the study material remain 19 largely ignored and the mechanisms 20 of complications are still poorly 21 understood". 22 A. That's correct. 23 Q. Under "method" you write: 24 "130 meshes excised from 25 different anatomical sites were</p>	<p>1 My question for you is whether this 130 2 meshes includes Gore-Tex and combined designs in 3 addition to polypropylene mesh? 4 A. No. This would just be POP and 5 knitted polypropylene meshes. 6 Q. And then you describe here some 7 findings that we've already discussed in 8 relationship to your other article with Dr. Carey, 9 correct? 10 A. That's correct. 11 Q. Are there any findings reported 12 here that are different, or in addition to the 13 findings reported in the full length article that 14 you authored with Dr. Carey and Dr. Steege? 15 A. Um, this was a smaller abstract 16 which, as you can see, combine transvaginal meshes, 17 slings and POP devices and hernia meshes. So this 18 is more of a descriptive study of all meshes, 19 irrespective of their anatomical location. Where 20 other papers were concentrated on specific type of 21 transvaginal locations, whether slings or POP devices. 22 Q. And so it wouldn't be true to say 23 that the 120 specimens that you described in your 24 litigation report are all included in this 25 abstract, correct?</p>
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<p>1 studied in search of features 2 explaining the complications." 3 Did I read that correctly? 4 THE WITNESS: That's correct. 5 BY MS. BYARD: 6 Q. Did these 130 mesh specimens 7 include both hernia mesh and transvaginal mesh? 8 A. Yes. At that time, yes. 9 Q. Did they include any other 10 anatomical sites or types of polypropylene mesh? 11 A. What do you mean "types of 12 polypropylene?" Polypropylene mesh is 13 polypropylene mesh. Do you mean lightweight, 14 heavyweight or... 15 Q. I was just thinking of the 16 indication. 17 A. At that time, all 130 were needed 18 polypropylene meshes from hernia or a transvaginal 19 locations. 20 Q. And your report in the litigation 21 which has been marked as Exhibit 1196, you wrote 22 that the explanted transvaginal mesh specimens that 23 you've examined include slings and POP devices, 24 heavy and lightweight netted polypropylene and 25 Gore-Tex and combined designs.</p>	<p>1 A. You see the abstract was written 2 earlier, a few months earlier so... 3 Q. The reason why we get to 130 4 specimens is because you've included other types of 5 polypropylene mesh besides transvaginal mesh, 6 right? 7 A. At that point, yes. This was 8 total amount of polypropylene meshes I had in my 9 specimen pool. 10 Q. Can you tell me how many of these 11 130 specimens were transvaginal mesh? 12 A. Just below 100. I think you had 13 the table which I supplied in July that was 14 representing approximately the time of this -- 15 Q. Okay. 16 A. -- roughly. So I think I had 97 17 transvaginal meshes. If it was a different number, 18 then probably it was different at that point. But 19 what I recall was 97 transvaginal meshes. 20 Q. Okay. So including sources of 21 specimens from -- provided to you from Plaintiffs' 22 counsel in the mesh litigation? 23 MR. ORENT: Objection. 24 BY MS. BYARD: 25 Q. Correct?</p>

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<p>1 A. There was 97, yes.</p> <p>2 Q. You conclude that:</p> <p>3 "General lack of interest</p> <p>4 created a paradoxical gap of</p> <p>5 knowledge in the presence of</p> <p>6 abundant study material and readily</p> <p>7 available tools."</p> <p>8 Right.</p> <p>9 A. That's correct.</p> <p>10 Q. You continue:</p> <p>11 "The newly described findings</p> <p>12 need to be studied in correlation</p> <p>13 with clinical symptoms to guide</p> <p>14 future developments."</p> <p>15 Correct?</p> <p>16 THE WITNESS: That's correct.</p> <p>17 BY MS. BYARD:</p> <p>18 Q. This study doesn't describe any</p> <p>19 correlation of your histological findings with</p> <p>20 clinical symptoms, does it?</p> <p>21 A. No, not directly.</p> <p>22 Q. There is no conflict of interest</p> <p>23 disclosure in Exhibit 1200, right?</p> <p>24 A. It was provided later in the</p> <p>25 presentation, I believe. It's just the way it was</p>	<p>1 Polypropylene Meshes: A Finding</p> <p>2 Overlooked for Decades," by Dr. V. Iakovlev,</p> <p>3 Dr. S. Guelcher, Dr. R. Bendavid.</p> <p>4 BY MS. BYARD:</p> <p>5 Q. Exhibit 1201 will be passed to you</p> <p>6 here momentarily.</p> <p>7 MR. ORENT: This is 1201 you said?</p> <p>8 MS. BYARD: Correct.</p> <p>9 BY MS. BYARD:</p> <p>10 Q. The title of 1201 -- well, first I</p> <p>11 should ask, this is familiar to you, right?</p> <p>12 A. Yes. That's the same conference,</p> <p>13 the same submission process. The same journal, the</p> <p>14 same issue.</p> <p>15 Q. The title of this abstract is:</p> <p>16 "In vivo Degradation of Surgical Polypropylene</p> <p>17 Meshes: A Finding Overlooked for Decades."</p> <p>18 A. That's correct.</p> <p>19 Q. And this is published with</p> <p>20 Dr. Scott Guelcher and Dr. Bendavid, right?</p> <p>21 MR. ORENT: Guelcher.</p> <p>22 THE WITNESS: Guelcher.</p> <p>23 BY MS. BYARD:</p> <p>24 Q. Thank you. And Dr. Guelcher is a</p> <p>25 paid Plaintiffs' expert like you, correct?</p>
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<p>1 published.</p> <p>2 I think I gave disclosures during</p> <p>3 submission. But the way they publish it, there's</p> <p>4 no disclosure. I can see there's no other</p> <p>5 disclosures for any other abstracts.</p> <p>6 Q. There's not a disclosure that</p> <p>7 appears here in Exhibit 1200, is there?</p> <p>8 A. On the paper, no.</p> <p>9 MR. ORENT: Objection.</p> <p>10 THE WITNESS: But it doesn't mean that</p> <p>11 it was not provided, or was not disclosed elsewhere</p> <p>12 assuming for presentation.</p> <p>13 If it's a presentation, I give slide</p> <p>14 with some disclosure, which is usually first slide</p> <p>15 before the presentation.</p> <p>16 BY MS. BYARD:</p> <p>17 Q. Okay. If you're able to find the</p> <p>18 disclosure form that you think you might have</p> <p>19 completed for this, would you provide it to counsel</p> <p>20 for me?</p> <p>21 A. I could not have it, because it</p> <p>22 was electronic submission.</p> <p>23 Q. Okay.</p> <p>24 EXHIBIT NO. 1201: Abstract entitled,</p> <p>25 "In-vivo Degradation of Surgical</p>	<p>1 MR. ORENT: Objection.</p> <p>2 THE WITNESS: Yes. He served as expert</p> <p>3 witness.</p> <p>4 BY MS. BYARD:</p> <p>5 Q. On the Plaintiffs' side, as far as</p> <p>6 you know, right?</p> <p>7 A. From those cases we've been</p> <p>8 involved together, yes, he was on Plaintiffs' side.</p> <p>9 Could have been on manufacturer side for something</p> <p>10 else.</p> <p>11 Q. But as far as you know, it's been</p> <p>12 on the Plaintiffs' side, right?</p> <p>13 MR. ORENT: Objection.</p> <p>14 THE WITNESS: I don't make the</p> <p>15 distinction. Because as I said, I mean, this is up</p> <p>16 to me to decide, or any other reader if there is a</p> <p>17 bias on which side and how it is presented.</p> <p>18 BY MS. BYARD:</p> <p>19 Q. My only question is, as far as you</p> <p>20 know, he served as a testifying expert for</p> <p>21 Plaintiffs against mesh manufacturers, correct?</p> <p>22 A. That's correct.</p> <p>23 Q. Under "Objectives", you write:</p> <p>24 "Surgical polypropylene meshes</p> <p>25 introduced over 50 years ago are</p>

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<p>1 excised in up to 10 percent for 2 complications." 3 Did I read that correctly? 4 A. Yes. 5 Q. Is this a statistic for hernia 6 mesh or for transvaginal mesh? 7 A. This is difficult now to remember. 8 Because it was based on all of those. So "up to" 9 means the highest number I could see in 10 sufficiently reliable source. 11 Q. Sometimes the rate is lower than 12 that in the reported literature, true? 13 A. It's a range. I mean, if you take 14 small sample size, one single mesh which has not 15 been excised, you don't have any rate. If a sample 16 size goes larger, then you get more or less 17 representative sample of the whole population. 18 Q. For this statement, were you 19 including literature on rates of removal from both 20 hernia repair and transvaginal mesh repairs? 21 A. It was pertinent to both. So I 22 don't remember exactly if 10 percent was for hernia 23 or transvaginal. I suspect it could have been for 24 transvaginal from what I remember. 25 Q. You write:</p>	<p>1 A. Yes. 2 Q. That study has not yet been 3 completed, true? 4 A. What exactly? Which study? 5 Q. The study of the role of 6 degradation in the development of complications? 7 A. It doesn't state it there as a 8 study. 9 Q. You write: 10 "The discovery opens the door 11 to study the role of degradation in 12 the development of complications". 13 A. Yes. But it doesn't state that we 14 have a study ongoing to do that. "Study" is used 15 as a verb here not as a noun. 16 Q. You haven't yet published anything 17 on the role of degradation and the development of 18 complications, right? 19 A. On exact mechanisms? No. 20 Q. There is no conflict of interest 21 disclosure in Exhibit 1201 for you, is there? 22 MR. ORENT: Objection. Asked and 23 answered. 24 THE WITNESS: The same thing. During 25 submission there was an option, if there was an</p>
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<p>1 "We studied 103 explanted 2 meshes and different designs, 3 manufacturers and anatomical sites 4 using conventional and transmission 5 electron microscopy." 6 Correct? 7 A. That's correct. 8 Q. Why are we at 103 here, compared 9 to the sample size of 120 we saw in Exhibit 1200? 10 A. Multiple reasons. It could be 11 different point in time when this abstract was 12 written. Something else, like not completed study 13 at that time, because I would need polarize or 14 measure the degradation thickness; so I don't know. 15 But at that time when the abstract was written, 16 total number was 103. 17 Q. You conclude this abstract by 18 writing: 19 "The discovery --" and you're 20 referring to the discovery of 21 degradation under microscopy 22 "-- opens the door to study the role 23 of degradation in the development of 24 complications." 25 Right?</p>	<p>1 option, submitted all information I could during 2 presentations. If it's PowerPoint presentation, 3 the first slide which appears after the title slide 4 is disclosure of conflict. 5 BY MS. BYARD: 6 Q. A conflict of interest disclosure 7 does not appear in Exhibit 1201, does it? 8 MR. ORENT: Objection. 9 THE WITNESS: It's up to a journal. 10 BY MS. BYARD: 11 Q. Is there a conflict of interest 12 disclosure that appears in Exhibit 1201, sir? 13 MR. ORENT: Objection. 14 THE WITNESS: I don't see it. 15 Maybe it was somewhere at the end of 16 the journal issue, I don't know. I mean, this is 17 just a page from the issue. Maybe they had 18 conflict of interest gathered at the end. 19 BY MS. BYARD: 20 Q. I'd like to turn back to your 21 report, which is Exhibit 1196. 22 Are you on the "Opinion" section with 23 me, sir? 24 A. Which page number? 25 Q. Five, please. You write that:</p>

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<p>1 "Explanted mesh specimens show</p> <p>2 non-specific reaction of the body to</p> <p>3 a foreign object, as well as findings</p> <p>4 specific for a mesh type or an</p> <p>5 anatomical location."</p> <p>6 Is that right?</p> <p>7 A. That's correct.</p> <p>8 Q. You continue:</p> <p>9 "Findings for abdominal mesh</p> <p>10 explants differ from findings for</p> <p>11 vaginal mesh implants."</p> <p>12 A. That's correct.</p> <p>13 Q. How so?</p> <p>14 A. I've explained some of the</p> <p>15 differences earlier. Hernia meshes are placed in</p> <p>16 parallel to anatomical planes. There are</p> <p>17 separated, well defined planes between fascia,</p> <p>18 adipose tissue, muscle and transvaginal</p> <p>19 allocations. There is no fascia, really, there's</p> <p>20 no anatomical plane. The tissue gradually</p> <p>21 transitions into -- one to another.</p> <p>22 Another difference is that functionally,</p> <p>23 abdominal wall is just holding pressure of --</p> <p>24 abdominal pressure. While vaginal tissue has</p> <p>25 completely different purpose. There is more</p>	<p>1 A. Yes. They are important to</p> <p>2 understand. I mean, everything is important to my</p> <p>3 opinion, because I wouldn't be providing this</p> <p>4 opinion if I didn't go to medical school. So you</p> <p>5 have to go back to 1986.</p> <p>6 Q. I don't think we have time for</p> <p>7 that, unfortunately.</p> <p>8 Under paragraph 2 of your opinions,</p> <p>9 there's a sentence that reads:</p> <p>10 "This reaction --" and you're</p> <p>11 talking about the foreign body</p> <p>12 reaction "-- persists until the</p> <p>13 inciting agent is either removed, in</p> <p>14 parenthesis, [expelled or reabsorbed]."</p> <p>15 Are you with me?</p> <p>16 A. "Resorbed".</p> <p>17 Q. Resorbed. Thank you.</p> <p>18 Does there come a point in time, in the</p> <p>19 tissue response to mesh, where the inflammatory</p> <p>20 response reaches a chronic or steady state?</p> <p>21 A. Foreign body reaction is a chronic</p> <p>22 inflammatory reaction.</p> <p>23 When it starts, it may start acutely</p> <p>24 but on its own it's a chronic response. Not may</p> <p>25 start; it starts acutely after the placement of</p>
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<p>1 mobility, there is stress of bladder expansion,</p> <p>2 bowel movement, then stress of intercourse.</p> <p>3 Muscles within the bladder wall,</p> <p>4 muscles within the vaginal wall which contract,</p> <p>5 type of innervation is completely different.</p> <p>6 Where in the abdominal wall, it mainly</p> <p>7 serves as a passage of nerves parallel to abdominal</p> <p>8 wall, where the vagina is practically the target of</p> <p>9 innervation, because the endings are there, and the</p> <p>10 nerves are in different orientation.</p> <p>11 And I can continue on and on, I mean</p> <p>12 it's -- abdominal wall is a completely sealed</p> <p>13 environment, there's no contamination. Vaginal</p> <p>14 environment is contaminated. Do you want me to</p> <p>15 continue?</p> <p>16 Q. Are those the main differences</p> <p>17 that you're noting?</p> <p>18 A. I mean --</p> <p>19 Q. Those are the ones that are</p> <p>20 important to your opinions here?</p> <p>21 A. I can continue more with the</p> <p>22 differences.</p> <p>23 Q. Are they relevant to your opinions</p> <p>24 in this report, the other differences besides those</p> <p>25 that you've mentioned?</p>	<p>1 foreign body, and then continues on as a chronic</p> <p>2 response.</p> <p>3 Q. Does the foreign body response</p> <p>4 drop off over time?</p> <p>5 A. Not in what I see. In relation to</p> <p>6 polypropylene, I see even -- I think my oldest</p> <p>7 specimen was 12 years after insertion, and I still</p> <p>8 see inflammatory -- chronic body -- chronic foreign</p> <p>9 body type reaction.</p> <p>10 So in relation to polypropylene, it's a</p> <p>11 variable. But I've never seen it went away</p> <p>12 completely.</p> <p>13 Q. Does the foreign body reaction</p> <p>14 drop off after this acute phase that you've</p> <p>15 described? And I don't mean completely, but just</p> <p>16 decrease?</p> <p>17 A. That was one of the questions.</p> <p>18 And I would expect that it would decrease, but so</p> <p>19 far have not been able to show it. Every time I'm</p> <p>20 checking, every time data builds up and then I</p> <p>21 check if there is correlation between foreign body</p> <p>22 reaction, what degree, and I'm just -- it doesn't</p> <p>23 correlate yet.</p> <p>24 Maybe I need to go to a thousand cases</p> <p>25 and then I see some weak correlation. What seems</p>

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<p>1 to be a case that it's variable between</p> <p>2 individuals, or maybe it's variable within the same</p> <p>3 individual, so it fluctuates with time. But again,</p> <p>4 that's why we need to study all this.</p> <p>5 Q. So those conclusions haven't been</p> <p>6 established yet, based on your observations to</p> <p>7 date?</p> <p>8 MR. ORENT: Objection.</p> <p>9 THE WITNESS: What exactly defines the</p> <p>10 degree of foreign body reaction? No, the degree is</p> <p>11 not.</p> <p>12 I mean, we know --</p> <p>13 BY MS. BYARD:</p> <p>14 Q. The degree -- and I guess what I'm</p> <p>15 focusing on is, it's activity over time?</p> <p>16 A. Yes. This is not completely</p> <p>17 understood. What we know, it is present and it is</p> <p>18 always present.</p> <p>19 Q. Okay.</p> <p>20 A. In all specimens.</p> <p>21 Q. You write here in your third</p> <p>22 paragraph that:</p> <p>23 "A mesh is a large foreign body</p> <p>24 in comparison to regular surgical</p> <p>25 sutures." Right?</p>	<p>1 that was. I mean, I just don't remember now.</p> <p>2 Q. Okay. And that's fine. And I</p> <p>3 think your testimony in response to my question</p> <p>4 about how many sutures are placed, for example,</p> <p>5 during abdominal paravaginal repair, is that you</p> <p>6 don't know for certain that the amount of materials</p> <p>7 are less than with the surgical mesh; is that fair?</p> <p>8 A. Significantly less, that is fair.</p> <p>9 Q. You write in paragraph 4 of your</p> <p>10 opinions, and I'm just reading part of the sentence</p> <p>11 that I want to ask you about is that:</p> <p>12 "The filaments --" here you're</p> <p>13 referring to vaginal mesh "-- are</p> <p>14 always surrounded by fibrous scar."</p> <p>15 Do you see that?</p> <p>16 A. Yes.</p> <p>17 Q. Is it true that you see tissue</p> <p>18 changes to mesh adjacent to the mesh, but at some</p> <p>19 point you see a resumption in normal tissue</p> <p>20 response?</p> <p>21 A. What do you mean, "resumption of</p> <p>22 normal tissue response?"</p> <p>23 Q. So you see a foreign body reaction</p> <p>24 and chronic inflammatory state in the tissue</p> <p>25 immediately adjacent to the mesh, correct?</p>
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<p>1 A. That's correct.</p> <p>2 Q. Do you note how many surgical</p> <p>3 sutures are used, for example, in abdominal</p> <p>4 paravaginal repairs?</p> <p>5 A. They're not placed every</p> <p>6 millimeter or so, that's for sure. Much smaller</p> <p>7 amount than a mesh would be.</p> <p>8 Q. Have you ever seen the performance</p> <p>9 of an abdominal paravaginal repair?</p> <p>10 A. I've seen some surgeries, I</p> <p>11 assisted to some surgeries. And definitely there</p> <p>12 are not that many sutures, in any surgery, I would</p> <p>13 say.</p> <p>14 In any type of surgery, you probably</p> <p>15 now ask me for specific surgical techniques. No</p> <p>16 surgeon will insert that many sutures, that much of</p> <p>17 foreign body in the -- during the surgery. There's</p> <p>18 no need for that.</p> <p>19 Q. My question to you, sir, was</p> <p>20 whether you've ever seen an abdominal paravaginal</p> <p>21 repair performed; and I think your testimony is</p> <p>22 that you can't say for certain you have seen</p> <p>23 abdominal pelvic surgeries performed?</p> <p>24 A. I have seen some pelvic abdominal</p> <p>25 surgeries, but I don't know exactly what type of</p>	<p>1 A. That's correct.</p> <p>2 Q. But at some point and distance</p> <p>3 away from the mesh, you see the body return to</p> <p>4 normal tissue responses, correct?</p> <p>5 A. There is no response. Tissue</p> <p>6 response is abnormal tissue, which doesn't respond;</p> <p>7 that's normal.</p> <p>8 Q. Okay.</p> <p>9 A. So --</p> <p>10 Q. So then maybe if we can --</p> <p>11 THE WITNESS: -- there is an edge ----</p> <p>12 MR. ORENT: Hold on. Slow down and let</p> <p>13 him answer.</p> <p>14 THE WITNESS: There is an edge of</p> <p>15 changes of scarring, and then there is normal</p> <p>16 tissue. So if you use word "response," it means</p> <p>17 abnormal already.</p> <p>18 BY MS. BYARD:</p> <p>19 Q. Okay, thank you for that</p> <p>20 correction.</p> <p>21 There's an edge that you see away from</p> <p>22 the mesh, where there's a resumption in normal</p> <p>23 tissue?</p> <p>24 A. Yeah. Interface between scar and</p> <p>25 normal tissue.</p>

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<p>1 Q. Have you measured to find a range 2 at which the average return to normal tissue is 3 from the mesh? 4 A. I don't think you're using words 5 "return" is not -- 6 Q. Okay. 7 A. It's not applicable. You don't 8 know if it was scar and then return -- actually, 9 it's impossible. 10 Q. Okay. So is there, I guess -- and 11 help me with how to phrase it. But is there a 12 distance -- have you measured -- let's start over. 13 Have you measured how far away from the 14 mesh the tissue ordinarily appears normal? 15 A. Yes. I didn't perform statistical 16 analysis or study, but I measured approximately 17 what's the distance of changes. 18 Q. And what is that distance on 19 average? 20 A. It's within one to two millimeters, 21 not greater than two, at least from most of the 22 cases I see. 23 Q. So in most instances, when looking 24 at a transvaginal mesh and tissue specimen, you 25 will see normal tissue one to two millimeters from</p>	<p>1 THE WITNESS: Thank you. 2 THE VIDEOGRAPHER: Off the record at 3 2:44 p.m. 4 -- RECESS AT 2:44 -- 5 -- UPON RESUMING AT 4:35 -- 6 THE VIDEOGRAPHER: We're back on the 7 record at 4:37 p.m. 8 BY MS. BYARD: 9 Q. Doctor, attached to your report 10 are a number of figures numbered 1 through 20, 11 correct? 12 A. Figure sets, I believe, sometimes 13 they are gathered in sets. 14 Q. Sitting here today, is it true 15 that you are not able to tell me what clinical 16 complications or symptoms led to each of these 17 patients whose specimens are depicted in Figures 1 18 through 20? Wait, let me start over, I don't think 19 I finished that right. Strike that. 20 Now, is it true that sitting here 21 today, you're not able to tell me that clinical 22 symptoms leading to these excision surgeries of 23 each of the patients whose specimens are depicted 24 in Figures 1 through 20? 25 A. You mean, do I remember the</p>
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<p>1 the mesh? 2 A. Yeah. From the most, outermost 3 point of mesh filament. Usually it's within one to 4 two -- or I would say, to be safe, one to three 5 millimeters. I don't see it exceeding three 6 millimeters, unless there is something else, like 7 an abscess. 8 If there's an abscess, then there is 9 much more scarring in the area. Or, if there is 10 erosion, there's inflammation, there is much more 11 damage to the tissue, then it expands. 12 But if we go into deep environment and 13 changes which can be only attributed to mesh, then 14 it's within three millimeters beyond the mesh. 15 But, if the mesh is curled, or folded 16 like POP, the distance between two mesh planes in 17 the fold can be much greater, five, six millimeters, 18 and this will all be filled by scar. I'm talking 19 about extent towards normal tissue. 20 Q. That's what I was asking. 21 A. Externally, yes. 22 Q. Okay. Good. 23 MS. BYARD: Doctor, I want to keep you 24 on schedule, so I know we need to break for an 25 appointment. Let's do that now.</p>	<p>1 history for a specific photograph and -- 2 Q. (Nods). 3 A. I don't. Is it what you meant? 4 Q. Yes, that was what I meant. Thank 5 you. 6 A. I don't remember histories, I 7 mean, they are all collected from Boston Scientific -- 8 or most of them. If it's not, they are specified 9 to be a known Boston Scientific. 10 Q. Okay. And so similarly, you 11 aren't able to tell me that for the figures 12 numbered 1 through 20, when any symptoms began, 13 that led to the excisions resulting in the 14 specimens whose -- that are depicted in Figures 1 15 through 20, right? 16 MR. ORENT: Objection. 17 THE WITNESS: When specific symptoms 18 began? 19 BY MS. BYARD: 20 Q. (Nods.) 21 A. No, I cannot. 22 Q. Okay. Thank you, Doctor. 23 Returning to your report and 24 paragraph 5; do you have that there in front of 25 you?</p>

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<p>1 A. Yes.</p> <p>2 Q. I just want to look at one</p> <p>3 sentence there at the end, where you write that:</p> <p>4 "Mature scar tissue after</p> <p>5 non-mesh surgeries --"the sentence</p> <p>6 continues "-- can remodel with time."</p> <p>7 Can you see that?</p> <p>8 A. Yes, I do.</p> <p>9 Q. Is it your opinion that scar</p> <p>10 tissue from mesh surgeries can't remodel with time?</p> <p>11 A. Cannot or can?</p> <p>12 Q. Cannot.</p> <p>13 A. It can. It can remodel, but the</p> <p>14 mesh cannot remodel.</p> <p>15 Q. So the scar tissue -- I'm sorry.</p> <p>16 A. So there will always be scar</p> <p>17 around the mesh. If mesh travels, migrates, the</p> <p>18 scar will remodel.</p> <p>19 So does that answer your question?</p> <p>20 Q. Yes, it does.</p> <p>21 So you would agree with me that scar</p> <p>22 tissue surrounding mesh can remodel over time?</p> <p>23 A. Yes, it can.</p> <p>24 Q. Okay. The sentence continues that:</p> <p>25 "Mature scar tissue from</p>	<p>1 ahead.</p> <p>2 THE WITNESS: We have to kind of</p> <p>3 separate it, other clinical publications saying</p> <p>4 that mesh -- non-mesh surgeries are free of</p> <p>5 complications?</p> <p>6 No. Because any surgery has a form of</p> <p>7 complication -- early complications, or later</p> <p>8 complications. I mean, it depends what surgery. I</p> <p>9 mean, then again, it's so broad and kind of worded</p> <p>10 in --</p> <p>11 BY MS. BYARD:</p> <p>12 Q. Okay, sure. And I just wanted to</p> <p>13 see if we could agree that non-mesh surgeries can</p> <p>14 also result in long-term clinical complications?</p> <p>15 MR. ORENT: Objection.</p> <p>16 THE WITNESS: Which -- I mean, any</p> <p>17 surgery will have specific complications. Early or</p> <p>18 later, we have to take specific surgery and then</p> <p>19 compare. Non-mesh surgery will not have long-term</p> <p>20 complications of meshes; that's clear.</p> <p>21 If there is no mesh, there will not be</p> <p>22 complications related to the mesh. If there is</p> <p>23 mesh, there can be complications related to the</p> <p>24 mesh.</p> <p>25</p>
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<p>1 non-mesh surgeries does not exhibit</p> <p>2 the same long-term reactions or</p> <p>3 clinical complications".</p> <p>4 Do you see that?</p> <p>5 A. That's correct.</p> <p>6 Q. I just want to focus on the term</p> <p>7 "clinical complications" with you, okay?</p> <p>8 Would you agree with me that there is</p> <p>9 no peer-reviewed published literature concluding</p> <p>10 that non-mesh surgical procedures are free of</p> <p>11 long-term clinical complications?</p> <p>12 MR. ORENT: Can you read that back?</p> <p>13 I'm sorry.</p> <p>14 THE WITNESS: I'm confused as well,</p> <p>15 yeah.</p> <p>16 REPORTER'S NOTE: Whereupon the</p> <p>17 question was read back as follows:</p> <p>18 "Would you agree with me that</p> <p>19 there is no peer-reviewed published</p> <p>20 literature concluding that non-mesh</p> <p>21 surgical procedures are free of</p> <p>22 long-term clinical complications?"</p> <p>23 THE WITNESS: You can state it for any</p> <p>24 type of -- well, not --</p> <p>25 MR. ORENT: I object to the form. Go</p>	<p>1 BY MS. BYARD:</p> <p>2 Q. So you can't cite for me, can you,</p> <p>3 what the rate of pain with a non-mesh</p> <p>4 perineorrhaphy is compared to a posterior repair</p> <p>5 with mesh; can you?</p> <p>6 MR. ORENT: Objection. Outside the</p> <p>7 scope.</p> <p>8 THE WITNESS: I'm not a clinician, so</p> <p>9 you have to ask other expert this question.</p> <p>10 BY MS. BYARD:</p> <p>11 Q. Okay, thank you.</p> <p>12 Your next paragraph, paragraph 6, deals</p> <p>13 with your opinions related to degradation, right?</p> <p>14 A. That's correct. Let me see.</p> <p>15 (Witness reviews document).</p> <p>16 Yes, that's correct.</p> <p>17 Q. As I understand it, there are</p> <p>18 three principle findings from which you conclude</p> <p>19 that polypropylene mesh degrades in vivo, all</p> <p>20 right?</p> <p>21 First you opine that the ability of the</p> <p>22 non -- I'm sorry, let me start over.</p> <p>23 First, you describe that the ability of</p> <p>24 the degradation bark to trap histological dyes,</p> <p>25 evidences degradation in vivo, right?</p>

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<p>1 A. No, this is not correct. You're</p> <p>2 mixing up things. So let's split it.</p> <p>3 If you want me to explain, I will</p> <p>4 explain. If you want me to answer your question, I</p> <p>5 will; what do you want?</p> <p>6 Q. Okay. Well, you have three -- you</p> <p>7 have three basic findings.</p> <p>8 A. No, no, not three. There are way</p> <p>9 more than three, but...</p> <p>10 MR. ORENT: Just let her --</p> <p>11 THE WITNESS: Okay.</p> <p>12 BY MS. BYARD:</p> <p>13 Q. Is it your opinion that</p> <p>14 polypropylene mesh degrades in vivo, in part</p> <p>15 because the degraded bark is able to trap</p> <p>16 histological dyes?</p> <p>17 A. No, this is not correct.</p> <p>18 Q. Explain it to me then.</p> <p>19 A. So let's dissect it.</p> <p>20 So first, what findings in the light</p> <p>21 microscope and electron transmission microscope</p> <p>22 through cross-sections prove that the layer I</p> <p>23 observe is polypropylene?</p> <p>24 So the first finding, light microscopy,</p> <p>25 it polarizes. So it behaves as polypropylene --</p>	<p>1 that it's polypropylene. So these would be</p> <p>2 findings in light microscope. And if we go to</p> <p>3 transmission electron microscopy, I can see</p> <p>4 transition. I see non-degraded, sort of finely</p> <p>5 granule, almost smooth, no granulation, sort of</p> <p>6 granularity. And then there's a smooth transition</p> <p>7 into smaller cracks, fine lattice of cracks, and</p> <p>8 then it expands, and expands, and expands in larger</p> <p>9 crevices towards the surface.</p> <p>10 So there's a range of degradation from</p> <p>11 a core to the surface. So this findings would</p> <p>12 confirm that this is -- this stainable layer is in</p> <p>13 fact polypropylene.</p> <p>14 Q. Okay. So then what was wrong with</p> <p>15 my question --</p> <p>16 MR. ORENT: Wait, hold on. He's not</p> <p>17 done.</p> <p>18 THE WITNESS: Then there's a next set</p> <p>19 of findings, which is proving that it is altered or</p> <p>20 degraded polypropylene.</p> <p>21 All right. First, we concluded that it</p> <p>22 is polypropylene. And the second set of findings</p> <p>23 proving that it's altered polypropylene.</p> <p>24 Obviously, first thing which is visible</p> <p>25 in light microscopy is it observes dye.</p>
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<p>1 non-degraded polypropylene in polarized light. So</p> <p>2 this is first finding.</p> <p>3 Second finding is that those mesh</p> <p>4 filaments where there are blue granules included, I</p> <p>5 observed them in this stainable layer. So this is</p> <p>6 another proof that it's coming from polypropylene.</p> <p>7 Then with other stains, as for one</p> <p>8 cause of stain, because the stainable layer is</p> <p>9 brittle, it cracks. So the first question for</p> <p>10 pathologists would be, can it be calcified</p> <p>11 material? Which is very common to have calcified</p> <p>12 material in human body, especially with long-term</p> <p>13 chronic processes. So I did Von Kossa stain,</p> <p>14 calcium stain, it's not -- it's not staining for</p> <p>15 calcium.</p> <p>16 The next set of stains was to stain for</p> <p>17 proteins, because if it's a protein, it mixes, it's</p> <p>18 a hydrophilic mix of some sort, to mix with</p> <p>19 proteins. So I stained it for several</p> <p>20 ubiquitous -- "ubiquitous" means present in many</p> <p>21 body fluids, immunoglobins, and it doesn't stain</p> <p>22 the layer. It's deposited right next to it, it</p> <p>23 goes into crevices, it follows the surface, but it</p> <p>24 doesn't mix. Again, this shows that the material</p> <p>25 is hydrophobic, and doesn't mix again; proof is</p>	<p>1 Non-degraded polypropylene is completely clear,</p> <p>2 it's solid, it doesn't have pores to trap dyes.</p> <p>3 The degraded polypropylene absorbs</p> <p>4 dyes. And, if I do staining with two stains, one</p> <p>5 is with small molecular size of the dye, and one is</p> <p>6 larger molecular size of the dye. The smaller</p> <p>7 molecule -- the dye with smaller molecule size will</p> <p>8 retain in smaller cracks, really fine sort of</p> <p>9 microcracks. And then larger molecules would stay</p> <p>10 in the larger.</p> <p>11 So, therefore, I had this trichrome</p> <p>12 stain layer of red, which indicates smaller</p> <p>13 porosity we see in the degraded material, and then</p> <p>14 a layer of green color, which highlights a larger</p> <p>15 porosity material. So this is degraded in light</p> <p>16 microscopy.</p> <p>17 Cracking, that's another feature.</p> <p>18 Peeling off. So what happens, there is internal</p> <p>19 force -- it's like drying, it's like drying on lips</p> <p>20 or like rust on the surface of the metal. Because</p> <p>21 it shrinks somewhat, and then the internal force</p> <p>22 pulls it, there's a crack, but it pulls and sloughs</p> <p>23 off of non-degraded surface, and then it starts</p> <p>24 peeling.</p> <p>25 So that's another feature showing that</p>

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<p>1 it's degrading, it's changing properties, physical 2 properties and it's non-degraded material. 3 BY MS. BYARD: 4 Q. Okay. 5 A. And then there is a third set of 6 findings, which proves that it happens in vivo. So 7 "in vivo" means that it happens before it is -- 8 Q. Explanted? 9 A. Piece of mesh is excised. So one 10 of the findings is that some surgeries are done 11 with electric cautery devices. So the edges of the 12 specimen are burned, and it melts polypropylene. 13 So this sides, I can see that the degraded material 14 melted, and non-degraded material melted. And then 15 they melt together and form one pool, and they 16 merge together and crystalize together. 17 So this also shows that it is 18 polypropylene, because in melted state, they're 19 compatible. So they can recrystallize on their own. 20 But, it also indicates that the tool 21 was touching it when it was already present. So it 22 means that it was forming in vivo, before it was 23 burned. 24 Another feature shows that it was in 25 vivo, is when I measure degradation layer and</p>	<p>1 because it's dead then, they get stuck. So this is 2 another process. Degraded material was present in 3 vivo, while the inflammatory cells were mobile, so 4 they could do that. So that's kind of overview. 5 Q. And maybe we're talking past each 6 other. What I was focusing on was paragraph 6. 7 And there you list its ability to trap histological 8 dyes, right? 9 A. That's proof that it's altered. 10 Q. There you also list that it 11 retains inclusions of blue granules? 12 A. That's proof that it was protein, 13 that it's originating from original protein. Not 14 protein, I'm sorry. Polypropylene. That it 15 originates from polypropylene, which was 16 manufactured with inclusion of blue granules. 17 Q. And then you list optical 18 properties in polarized light, right? 19 A. Yes. Which are very different 20 from anything else in the body, and this shows as 21 well that it's polypropylene. 22 Q. Okay. So those were the three 23 buckets I was talking about that were listed there 24 in paragraph 6. 25 A. Yup. But then there is a</p>
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<p>1 correlated it with time, it was gradually growing 2 over the years. So the first time when you can see 3 it with light microscope, is probably about a year 4 or two in vivo. And then there is a rapid growth 5 which later on plateaus and goes really slow, which 6 is biological response. I mean, it grows to a 7 specific thickness, and then the rate of growth 8 slows down. So this also proves that it forms in 9 vivo. 10 Another thing I said, I put new meshes 11 in formalin, and kept them in formalin up to four 12 months, and then kept them -- and put them for 13 processing and examined them. There's no 14 degradation bark after four months. So, expose it 15 to formalin up to four months, it doesn't form 16 degradation. Again, if degradation is present and 17 formalin doesn't cause it, it was present before 18 surgery. 19 And then for transmission electron 20 microscopy, the fact that inflammatory cells could 21 migrate partially in the cracks, into crevices and 22 expand, that's what they normally do, inflammatory 23 cells go through very tight spots to migrate 24 through the vessel walls. They try to do the same 25 thing into the cracks of degraded material, but</p>	<p>1 description in the pictures with figure captions 2 further going into the details. 3 Q. Okay. I understand that. 4 Have you just described for me all of 5 the findings that you've made that lead you to 6 conclude that polypropylene degrades in vivo? 7 A. I think most. 8 Q. I think so. 9 Can you identify for me, any 10 peer-reviewed published literature, besides your 11 own that we've looked at, that describe these three 12 findings that are set forth in paragraph 6? 13 A. Okay. So you have to remind me 14 which three findings; the blue granules? 15 Q. Blue granules, ability to track 16 histological dyes, and optical properties in 17 polarized light? 18 A. Blue granules, no. Polarized 19 light has been used to identify foreign materials 20 for decades. 21 Q. Okay. But not degradation? 22 A. Including degradation. 23 Q. Of polypropylene? 24 A. Not poly -- well, polypropylene 25 is, no; because sutures were around. So what</p>

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<p>1 pathologists do, they see something, it's clear, 2 it's not sure if it's foreign or a native tissue, 3 polarize and see what's the state of it. 4 Specifically for degradation bark, the 5 way I describe it, no. But, I mean, generally, 6 pathologists identify foreign bodies, including 7 polypropylene sutures, and they assess the state 8 they are in. 9 Q. My question is more narrow than 10 what you're responding to, okay? 11 My question is simply whether there is 12 peer-reviewed published literature besides your own 13 that we've looked at, that describes finding of 14 degradation of polypropylene with polarized light? 15 MR. ORENT: Objection. Misstates the 16 opinions of Dr. Iakovlev. 17 THE WITNESS: As I said, the state of 18 polypropylene sutures and the examination in 19 polarized light has been described before. Nobody 20 coined it as I did as a bark, and went into these 21 details, that's true. 22 But, was it used to see if 23 polypropylene is there and if it's in degraded 24 state or -- yes. 25</p>	<p>1 THE WITNESS: Specifically for 2 polypropylene, yes, I'm the first one. 3 BY MS. BYARD: 4 Q. Let's talk a little bit about how 5 specimens get to you from the surgical location, 6 all right? In order to understand it and breakdown 7 what you've said here in paragraph 6 a little bit 8 better. 9 You would agree with me that all the 10 specimens that you've reviewed were excised during 11 surgery by a physician, right? 12 A. That's correct. 13 Q. And apart from what's described in 14 the operative report of the excision, you don't 15 know beyond that, what was done to remove the mesh, 16 correct? 17 A. Specific details, no. The only 18 thing I need to assess as a pathologist, is 19 acceptable for examination and to what degree I can 20 examine it. 21 Q. Okay. And my question is a little 22 different. 23 My question is, beyond what's set forth 24 in the op report describing this excision 25 procedure, you don't know the details of what the</p>
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<p>1 BY MS. BYARD: 2 Q. Can you point me to an article 3 that talks about identifying degradation of 4 polypropylene sutures through the use of polarized 5 light? 6 A. I'd have to search for it, but as 7 I said, I mean, generally the tool is there and for 8 diagnostic surgical pathologists they see foreign 9 material, they have to assess what state it is in. 10 Q. Can you name an article for me, 11 Doctor? 12 A. I cannot do it now, but I would 13 have to search for that, but... 14 Q. Okay, thank you. 15 Similarly, can you give me the name of 16 an article, a peer-reviewed published article, that 17 talks about identification of degraded polypropylene 18 by its ability to trap histological dyes? 19 MR. ORENT: Objection. 20 THE WITNESS: That is also my 21 description. 22 BY MS. BYARD: 23 Q. Okay. You are the only one who 24 has reported that finding, correct? 25 MR. ORENT: Objection.</p>	<p>1 surgeon did to remove that specimen, correct? 2 A. No, it's irrelevant to my 3 practice. I don't ask it even if there were other 4 regular diagnostic specimens. 5 Q. Okay. So the answer to my 6 question is "no" -- 7 MR. ORENT: Objection. 8 BY MS. BYARD: 9 Q. -- and you would also add that 10 it's not relevant to you? 11 A. That's correct. 12 Q. Okay. And again, unless it's set 13 forth in the operative report, you don't typically 14 know what instruments the doctor used to excise 15 this specimen, correct? 16 MR. ORENT: Objection. 17 THE WITNESS: I can deduct it from what 18 I see. If I see cautery, then they used cautery. 19 If I see depth of the changes in the tissue and so 20 forth. 21 So, essentially, what I do, I go by 22 what I see. And if something is different, then 23 there are specific features to assess what happened 24 to a specimen. 25</p>

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<p>1 BY MS. BYARD: 2 Q. For instance, are you able to 3 discern whether the doctor used a scalpel or 4 Metzenbaum scissors? 5 A. It doesn't matter to me. I mean, 6 this is completely irrelevant. 7 Q. Okay. So the answer to my 8 question is, no, you're not able to discern that, 9 right? 10 A. No, I don't know why you're asking 11 me this. 12 Q. Doctor, I just -- I just am asking 13 you my questions. If you understand where they're 14 coming from or not, is okay. But I just need 15 answers so that we can move along, all right? 16 A. Okay. 17 Q. Okay. So the answer to my 18 question is that you can't discern whether scalpel 19 or scissors were used, for example? 20 MR. ORENT: Objection. 21 THE WITNESS: I can discern if it was 22 hot or cold instrument. 23 BY MS. BYARD: 24 Q. Okay, thank you. 25 A. Or if it was crushing or sharp,</p>	<p>1 and piecemeal -- not necrose -- sorry, I'm a little 2 bit. 3 If it's piecemealed resection and it's 4 raggedy, it's clear that it was difficult excision. 5 If it's cleanly excised, no damage to it, I mean, 6 it's clear that it was easy excision. 7 Q. In the litigation context, you 8 don't review the depositions of the excising 9 surgeons, right? 10 A. No. 11 Q. You don't speak to the excising 12 surgeons in the litigation context, do you? 13 A. No. 14 Q. Generally, though, you do know 15 that doctors when excising specimens, need to grip 16 the area of mesh that they're removing in order to 17 accomplish the surgery, right? 18 A. Of course. 19 Q. And unless it's set forth in the 20 operative report, you don't know what 21 instrumentation was used to grip the mesh, correct? 22 A. No. 23 Q. Similarly, to the extent that 24 distortions to the mesh occur as the doctor is 25 cutting and removing it, you're not able to tell</p>
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<p>1 that I can discern, but not beyond that. 2 Q. Thank you. And again, apart from 3 what's set out in the operative report, you can't 4 identify what degree of force, if any, was used to 5 excise the specimen, correct? 6 MR. ORENT: Objection. 7 THE WITNESS: I can only define the 8 degree of manipulation instrument or other handling 9 affected it to a degree where I cannot assess if 10 it's acceptable or not; that's what I can assess. 11 If the degree of manipulation was not 12 strong enough to alter it in the way it would 13 change microscopic appearance, then I cannot. But 14 then it becomes irrelevant, because it doesn't 15 affect my ability to interpret it. 16 BY MS. BYARD: 17 Q. And perhaps we can come back to 18 that in reference to some of the specific cases 19 tomorrow. But I'll move on for now. 20 On a similar line of questioning, you 21 don't typically know, unless it's set forth in the 22 operative report, what degree of difficulty the 23 surgeon encountered in removing this specimen, 24 correct? 25 A. Sometimes if it's really raggedy</p>	<p>1 whether that distortion occurred in vivo, or 2 whether it occurred during this removal process, 3 correct? 4 A. That is not correct. 5 Q. For example, if you are given two 6 specimens of mesh from a sling incision, you 7 couldn't say that the mesh was broken apart in the 8 women's body before it was removed, right? 9 A. This is not correct. 10 MR. ORENT: Objection. 11 THE WITNESS: Again, this is the second 12 incorrect statement. 13 BY MS. BYARD: 14 Q. Is the way that you would tell, 15 based on whether the -- both specimens are 16 encapsulated in scar tissue? 17 A. There are multiple other features 18 they can see. If damage was in the body, white 19 cell reaction, I mean, including scar 20 encapsulation, your guess was right. 21 Q. So after excision, the specimen is 22 sent to pathology and put in a jar of formalin? 23 A. That's correct. 24 Um, not always. Sometimes I let it 25 dry, so I had a few specimens which were left dry.</p>

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<p>1 Q. And I think you said the longest</p> <p>2 that you put your control sample of virgin mesh in</p> <p>3 a jar of formalin was four months?</p> <p>4 A. Up to four months, yes.</p> <p>5 Q. So from the operating room, the</p> <p>6 specimen goes to pathology at the patient's</p> <p>7 hospital or a local hospital typically, correct?</p> <p>8 A. That's correct.</p> <p>9 Um, if it is preserved, it goes to a</p> <p>10 lab through some channels. Some specimens are not</p> <p>11 preserved, they are discarded.</p> <p>12 Q. If the sample or specimen is</p> <p>13 examined by a local pathologist, it's examined</p> <p>14 grossly and/or microscopically, typically, right?</p> <p>15 A. There should be some form of</p> <p>16 examination, gross or microscopic; yes, that is</p> <p>17 correct.</p> <p>18 Q. Okay. You talked about the sample</p> <p>19 being preserved; what does that process entail?</p> <p>20 A. The main preservative is formalin,</p> <p>21 so it's kept in formalin.</p> <p>22 Q. For the litigation context, you</p> <p>23 received samples through a company called</p> <p>24 Steelgate, right?</p> <p>25 A. Most of the samples came through</p>	<p>1 operating room to the laboratory?</p> <p>2 A. After grossing. After I gross or</p> <p>3 somebody gross the specimen, they take sections, so</p> <p>4 it could fit in the cassettes. Then the cassettes</p> <p>5 are loaded in the machine, and then there's a</p> <p>6 process of dehydration, saturation of tissue with</p> <p>7 paraffin, and then the tissue can be cut when</p> <p>8 paraffin solidifies and then it can be cut.</p> <p>9 Q. Sometimes that dehydration and</p> <p>10 alcohol application and saturation with paraffin</p> <p>11 process happens in your laboratory for these</p> <p>12 litigation specimens, but sometimes they happen at</p> <p>13 the local hospital?</p> <p>14 A. That's correct.</p> <p>15 Q. How long does the process of</p> <p>16 applying increasing alcohol concentrations take?</p> <p>17 A. The machine can be programmed</p> <p>18 differently, but roughly it runs about, the full</p> <p>19 cycle is anywhere between 12 to 24 hours, with</p> <p>20 different solutions. The short --</p> <p>21 Q. Is it just alcohol?</p> <p>22 A. No, no. There are serial</p> <p>23 concentrations of alcohol increasing, and then</p> <p>24 xylene, and then xylene is replaced by paraffin.</p> <p>25 MR. ORENT: "Saline"?</p>
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<p>1 Steelgate, sometimes it comes from law firms</p> <p>2 directly or through Scisafe.</p> <p>3 Q. Spell that for me.</p> <p>4 A. I think it is Scisafe. S-C-I</p> <p>5 safe. My understanding is, it is a company similar</p> <p>6 to Steelgate.</p> <p>7 Q. So someone has, either Steelgate</p> <p>8 or Scisafe of a Plaintiffs' firm, sent those</p> <p>9 specimens to you at this point in the process from</p> <p>10 the operating room to your lab?</p> <p>11 MR. ORENT: Objection.</p> <p>12 THE WITNESS: Most of the specimens</p> <p>13 come from either law firms or depositor like</p> <p>14 Steelgate.</p> <p>15 Occasional specimens, when they are</p> <p>16 prospective, when the excision is planned, they</p> <p>17 come directly from the hospitals.</p> <p>18 BY MS. BYARD:</p> <p>19 Q. There is also a process of</p> <p>20 dehydration with increasing series of alcohol</p> <p>21 concentrations that are applied to the specimens,</p> <p>22 correct?</p> <p>23 A. That's correct.</p> <p>24 Q. Where does that process take place</p> <p>25 in these steps that we've outlined from the</p>	<p>1 BY MS. BYARD:</p> <p>2 Q. X-Y-L-E-N-E?</p> <p>3 A. That's correct.</p> <p>4 Q. Then paraffin?</p> <p>5 A. And all of those new meshes went</p> <p>6 through all the same steps, they were loaded in the</p> <p>7 same machine.</p> <p>8 Q. You anticipated my question.</p> <p>9 So the virgin mesh that you examined</p> <p>10 for degradation went through this alcohol</p> <p>11 dehydration?</p> <p>12 A. (Witness nods.)</p> <p>13 MR. ORENT: You have to say "yes".</p> <p>14 THE WITNESS: Yes. Yes, sorry.</p> <p>15 BY MS. BYARD:</p> <p>16 Q. They went through xylene</p> <p>17 treatment?</p> <p>18 A. They were loaded in the same rack,</p> <p>19 and the same basket as all other specimens, and</p> <p>20 then they went through exactly the same procedural</p> <p>21 steps.</p> <p>22 And also, those specimens which had</p> <p>23 different thickness of the degradation layer, they</p> <p>24 also went through all the same. But, the</p> <p>25 correlation was only between in vivo exposure and</p>

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<p>1 thickness of the degradation layer; there was no 2 correlation between the storage time. It showed 0 3 correlation. It was exactly like minus 0.06 or 4 something like this.</p> <p>5 While the correlation between in vivo 6 and thickness of the bark was .76 which is very 7 good for biological response.</p> <p>8 Q. Is this data somewhere where I 9 could look at it?</p> <p>10 A. The publication is almost 11 published. I mean, it's ready, it's written, so I 12 need to just submit it. And, hopefully, when it is 13 submitted soon, and it will be accepted, then I can 14 present it to you.</p> <p>15 Q. And until it's published, you 16 wouldn't share that because it's considered 17 confidential by you at this point --</p> <p>18 A. Yes.</p> <p>19 Q. -- is that fair?</p> <p>20 A. Yes. At this point it would be, 21 thoroughly.</p> <p>22 Q. Once the paraffin processing takes 23 place, the specimen is typically cut into a 24 four-micron thick slice with what's called a --</p> <p>25 A. Microtome.</p>	<p>1 immunoperoxidase stains to do the S100 nerve 2 observations?</p> <p>3 A. Yes. Immunoperoxidase stain is 4 technique for immunostains where antibodies labeled 5 against specific proteins. And then you choose 6 antibody against what protein you want to stain.</p> <p>7 Q. You describe in your study with 8 Dr. Carey, enzyme digestion for four minutes; what 9 is that, for a lay person?</p> <p>10 A. It's the way you try to reverse 11 affect of formalin on tissue. So how formalin 12 preserves tissue, it crosslinks proteins in a way 13 that bacteria cannot degrade it anymore.</p> <p>14 It's crosslinked, it ties up in a way 15 that bacteria cannot digest it. But then some of 16 the epitopes, it points where antibody is 17 connecting, are hidden in this sort of crosslink.</p> <p>18 So you have to un-crosslink, open it 19 up. And for some antigens, it's -- it's enzymes -- 20 usually, it is a protease, weakened protease.</p> <p>21 Q. And that's only applied for four 22 minutes?</p> <p>23 A. It depends, I mean, these are 24 tested -- sometimes manufacturer gives 25 instructions, sometimes we have to adjust it. I</p>
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<p>1 Q. Thank you. Sometimes for the 2 specimens that you reviewed in litigation, those 3 slices are made in your laboratory, but other times 4 they've already been made by the local hospital; is 5 that right?</p> <p>6 A. That's correct.</p> <p>7 Q. And then at some point in time 8 during this process from the operating room to your 9 laboratory, you apply stain, which you've talked to 10 me about?</p> <p>11 A. That's correct.</p> <p>12 Q. Does that take place after you've 13 prepared these four-micron thick slides?</p> <p>14 A. Yes.</p> <p>15 Q. And there is a staining called 16 hemotoxin and Eosin, H&E?</p> <p>17 A. Eosin, yes.</p> <p>18 Q. Eosin?</p> <p>19 A. Um-hum.</p> <p>20 Q. That's one stain that you might use?</p> <p>21 A. It's a basic standard stain, first 22 stain. Most commonly used in North America as an 23 initial stain. And most time it's the only stain 24 which is used.</p> <p>25 Q. You also performed staining with</p>	<p>1 mean, it's a quality assurance process. We use 2 standard tissue to validate the stain and other 3 things.</p> <p>4 Q. For instance, you describe in your 5 study with Dr. Carey that the enzyme or the 6 retrieval process is something like 36 minutes for 7 smooth muscle?</p> <p>8 A. I mean, either manufacturer 9 recommended that time, or we, in the lab, 10 determined that this is optimal time for retrieval, 11 antigen retrieval.</p> <p>12 Q. You also in this process of 13 staining the slide and using enzyme digestion to 14 examine the slide, or really to prepare the slide 15 for examination, you also incubate the slice?</p> <p>16 A. "Incubate" means when you apply 17 antibody, you need to give it time to work to find 18 it; so this is incubation.</p> <p>19 This time when you wait, apply antibody 20 and wait until you can proceed to other steps.</p> <p>21 Q. So for this process of dehydration 22 and xylene replacement, and paraffin embedding and 23 for enzyme digestion and incubation, are you 24 applying heat?</p> <p>25 A. 37 degrees, sometimes it's a</p>

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<p>1 little higher. I mean, there is a range of -- it 2 depends on what retrieval is done and how it is 3 done. But there is a degree of heating involved in 4 some of the techniques. 5 Q. Celsius, 37 degrees celsius? 6 A. 37 degrees celsius, sorry. I 7 completely forgot you're on a different scale. 8 Q. So as the specimen is undergoing 9 paraffin embedding for 12 to 24 hours, it may be 10 maintained at 37-degree celsius? 11 A. 37 or higher. I mean, depends. 12 Sometimes there's no retrieval at all, it just 13 stain it the way it is; without retrieval. So 14 there is no temperature, and no, um, higher 15 temperatures. 16 Q. If you were going to say that the 17 specimens are subjected to heat up to a certain 18 temperature, what would you -- what would be the 19 "up to" amount? 20 A. 90 degrees centigrade, highest. I 21 don't think it will go beyond in any of the steps. 22 Q. And where would you use those 23 higher temperatures for processing? 24 A. Paraffin. Usually, the highest 25 temperature would be melting point of a paraffin,</p>	<p>1 parts were -- and degraded were exposed to exactly 2 the same environment, heating chemicals. 3 BY MS. BYARD: 4 Q. And I'm not making a distinction 5 between the degraded and -- the degraded bark as 6 you've coined the term, and the non-degraded core. 7 I'm talking about the virgin samples of 8 mesh, off the shelf, that you examined? 9 A. Virgin tissue was exposed to 10 exactly the same temperatures and chemicals. 11 Q. I'm talking about virgin mesh. 12 A. Virgin mesh. Um, virgin mesh, 13 sorry. Yes. 14 Q. It was, okay. 15 Did you expose the virgin mesh to all 16 the same staining procedures that we've discussed? 17 A. H&E. 18 Q. Just H&E? 19 A. Yes. 20 Q. When you examine the mesh for the 21 litigation cases for whether or not the sample 22 absorbs dye, are you just using H&E stain? 23 A. I think it's incomplete question. 24 To observe what? 25 Q. In paragraph 6 where you talk</p>
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<p>1 maybe 80 degrees, maybe 90, I'm not sure now. 2 Because I think if it's too high, the paraffin is 3 brittle, it's melting point is high. If it's 4 lower, it becomes too soft. 5 I would say probably closer to 80 than 6 90. But I'm not sure, I mean, it all depends. 7 Q. Were the samples of virgin mesh 8 that you looked at for a control, and your 9 degradation observations, subjected to 80 to 10 90 degrees celsius? 11 A. Yes. I mean, that's only way to 12 embed it to melt paraffin. And, both the central 13 non-degraded part was also exposed. 14 So I think there's internal control in 15 each slide, non-degraded part is exposed to exactly 16 the same procedural steps. There's no dying in the 17 center, it remains clear. Therefore, all 18 procedural steps have no effect on polypropylene 19 degradation. 20 Q. My question was simply whether or 21 not the samples were exposed to 80 to 90 degrees 22 temperature, okay? 23 MR. ORENT: Objection. 24 THE WITNESS: Well, I mean, I just told 25 you that both virgin tissue and the non-degraded</p>	<p>1 about the absorption of the mesh of histological 2 dyes? 3 A. No. H&E and trichrome, and even 4 immunoperoxidase, its counterstain was hematoxylin 5 and it stains the degraded layer. 6 Any stain, any histological, 7 histochemical stain, will stain it. 8 Q. So what I want to understand is, 9 which dyes were applied to the virgin mesh, which 10 stains -- 11 A. H&E. 12 Q. -- were applied to the virgin 13 mesh, and then which stains were applied to the 14 mesh that you looked at for degradation? 15 A. For virgin mesh experiments, I 16 used only H&E. 17 For specimens, and all pictures are 18 there. I used H&E, trichrome stain, Gomori 19 trichrome stain, Masson trichrome stain, Von Kossa 20 stain, immunohistochemical stains. 21 Q. So one difference between the 22 virgin mesh samples, and the mesh samples that you 23 examined for degradation that were surrounded by 24 tissue, were the number of different stains that 25 you applied to those specimens, fair?</p>

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<p>1 MR. ORENT: Objection.</p> <p>2 THE WITNESS: Could you repeat the</p> <p>3 question?</p> <p>4 BY MS. BYARD:</p> <p>5 Q. Sure. So looking at specimens,</p> <p>6 mesh and tissue, you applied multiple different</p> <p>7 stains?</p> <p>8 A. For some --</p> <p>9 MR. ORENT: Objection.</p> <p>10 THE WITNESS: -- specimens, I only had</p> <p>11 H&E. For some specimens I had more than H&E.</p> <p>12 BY MS. BYARD:</p> <p>13 Q. Okay. But for the virgin mesh</p> <p>14 samples you only used H&E?</p> <p>15 MR. ORENT: Objection. Asked and</p> <p>16 answered.</p> <p>17 THE WITNESS: That is correct. Because</p> <p>18 there are no purpose for other stains.</p> <p>19 BY MS. BYARD:</p> <p>20 Q. When you looked at mesh for</p> <p>21 degradation, you never cleaned the samples to</p> <p>22 remove the tissue, right?</p> <p>23 A. No.</p> <p>24 Q. As a pathologist, are there</p> <p>25 processes that you would use to remove tissue from</p>	<p>1 Actually, you don't want tissue to be</p> <p>2 separated. You want tissue to hold the mesh.</p> <p>3 BY MS. BYARD:</p> <p>4 Q. Okay. You didn't remove tissue</p> <p>5 before you looked at the samples, and there is a</p> <p>6 way to do it?</p> <p>7 MR. ORENT: Objection. Compound asked</p> <p>8 and answered.</p> <p>9 THE WITNESS: Yes. That summarizes.</p> <p>10 BY MS. BYARD:</p> <p>11 Q. Okay. So when you're examining</p> <p>12 the mesh for degradation then in your report, you</p> <p>13 are looking at the mesh while it's still in the</p> <p>14 surrounding tissue, right?</p> <p>15 A. Most of the time. Occasional</p> <p>16 filaments are kind of sticking out, or they are</p> <p>17 cross section -- like the slice of salami falls</p> <p>18 off.</p> <p>19 Q. Okay. And in all the figures</p> <p>20 you've given us here in your report, all of the</p> <p>21 samples are embedded in tissue, right?</p> <p>22 A. Yes.</p> <p>23 Q. As I understand it, would these</p> <p>24 specimens that you receive, may have mesh that is</p> <p>25 oriented in the three-dimensional space of the</p>
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<p>1 a foreign body?</p> <p>2 A. I don't understand the question,</p> <p>3 or are you reading from --</p> <p>4 Q. I was asking. I was asking you,</p> <p>5 as a pathologist, are there processes that you</p> <p>6 would use if you wanted to remove tissue from a</p> <p>7 foreign body?</p> <p>8 A. No, not really. Because we cut</p> <p>9 through specimens, so it would be totally</p> <p>10 separated.</p> <p>11 Q. Okay. There's a way to do that if</p> <p>12 you wanted to, though, right?</p> <p>13 A. I read an article, some</p> <p>14 researchers use separation to observe the surface,</p> <p>15 yes.</p> <p>16 But we don't have to, because we slice</p> <p>17 across. For transmission electron microscopy, I</p> <p>18 got -- we're just cutting through it.</p> <p>19 Q. Okay. It's possible that you</p> <p>20 haven't done it, because you didn't feel the need</p> <p>21 to do that?</p> <p>22 MR. ORENT: Objection.</p> <p>23 THE WITNESS: Not just didn't feel.</p> <p>24 It's not needed, period. For cross-sections it's</p> <p>25 not needed.</p>	<p>1 specimen in different ways, right?</p> <p>2 A. Yes.</p> <p>3 Q. So when the knife of the microtome</p> <p>4 is cutting the specimen, you are not assured that</p> <p>5 the meshes that are completely perpendicular and</p> <p>6 angled to the knife blade, right?</p> <p>7 A. What do you define as the plane of</p> <p>8 the mesh?</p> <p>9 Q. So, mesh has a length, a fiber,</p> <p>10 and it has a width of fiber within its knitting</p> <p>11 structure, right?</p> <p>12 A. You mean individual mesh fibers</p> <p>13 or -- well, it's more or less filaments. So fiber</p> <p>14 and filament in this case is the same term.</p> <p>15 You mean individual filaments, if I</p> <p>16 know if they are entered perpendicular or</p> <p>17 obliquely? Of course I'd know. I mean, the shape,</p> <p>18 if it's perfect circle -- or close to perfect</p> <p>19 circle, it's close to perpendicular shape.</p> <p>20 If it's oblique, then you have the</p> <p>21 long, longitudinal section. So for specific</p> <p>22 filaments, it's easier. Because you can see it.</p> <p>23 For the whole mesh itself, it may not</p> <p>24 have a plane anymore, because it's all folded and</p> <p>25 it's -- there is no plane.</p>

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<p>1 Q. And the mesh might not be oriented 2 in the specimen, along the length of the specimen, 3 right?</p> <p>4 A. Let's separate. Filaments, 5 individual filaments and the mesh.</p> <p>6 Q. That's what I was trying to do. 7 You're the one who went to the mesh within the 8 larger specimen potentially being folded.</p> <p>9 Let's take out for now, just the 10 fibers, the filaments of mesh itself?</p> <p>11 A. That's okay.</p> <p>12 Q. So because you don't know how the 13 mesh is oriented in the specimen --</p> <p>14 A. Mesh filament or the mesh?</p> <p>15 Q. We'll get to that.</p> <p>16 So because you don't know how the mesh, 17 as a whole, is oriented in the specimen, you 18 similarly don't know how the individual fibers are 19 oriented in the specimen --</p> <p>20 A. No, this is not correct.</p> <p>21 Q. -- right?</p> <p>22 A. I can go -- mesh filament is 23 around the structure. So if it's cut 24 perpendicular, there is a round cross section. If 25 it is oblique, then you get an oval, and then</p>	<p>1 of angle from 90 degrees to almost, um, almost 2 parallel orientation, anywhere.</p> <p>3 I mean, pretty much any specimen if 4 it's large enough, you will find a range of angles.</p> <p>5 Q. So not every slide is a 90-degree 6 cross section of all of the mesh fibers contained 7 in that section of the specimen?</p> <p>8 A. That's correct.</p> <p>9 MR. ORENT: Objection.</p> <p>10 BY MS. BYARD:</p> <p>11 Q. Does polarized light reflect off 12 different thicknesses of material differently?</p> <p>13 A. I'm not sure exactly what you're 14 asking. If it brightens, it will be different if 15 the thickness of the material is different? Yes.</p> <p>16 If it's getting thicker, there will be 17 more material, it will -- to a certain degree, I 18 mean, that's to a certain degree I mean, so...</p> <p>19 Q. It will get brighter or dimmer?</p> <p>20 A. If it's clear, it will get -- to a 21 certain degree, it will get brighter. When it's 22 really thin, the brightness will be lower and then 23 it will build up. And then after a certain 24 thickness, it will not matter anymore. So it 25 reaches full capacity.</p>
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<p>1 sometimes you get a really long sort of cross 2 section.</p> <p>3 So just by the shape, I can tell you 4 exact, approximately what's angle.</p> <p>5 Q. Do you measure each one of the 6 mesh shapes that you look at to assure that they 7 are perfectly round?</p> <p>8 A. There is a bunch of different 9 shapes, and some of them are round, some of them 10 are oval. So the more longer oval you get, the 11 more angle -- I mean, more acute angle is.</p> <p>12 Q. And so the way that you've 13 represented mesh in your colorized figures is with 14 yellow, right?</p> <p>15 A. Yes.</p> <p>16 Q. And many of those shapes, you'll 17 concede, are not perfect circles, they're ovals; 18 aren't they?</p> <p>19 A. Yes. They are angled.</p> <p>20 Q. And so when the knife of the 21 microtome is cutting each specimen to create a 22 slide, each mesh fiber or filament is not being cut 23 at a 90-degree angle in every circumstance, 24 correct?</p> <p>25 A. That's correct. There is a degree</p>	<p>1 Q. Okay. So if I was looking at a 2 thinner amount of material that was clear, under 3 polarized light, it would be brighter or dimmer 4 than thicker amounts of that same material?</p> <p>5 A. If it's clear, because polarizable 6 materials may be clear or not clear, so then 7 there is a --</p> <p>8 Q. It's clear in this hypothesis.</p> <p>9 A. If it's clear, and it's really -- 10 if it gets thicker -- I mean, start from very thin, 11 barely visible. So the brightness of the light 12 will be dimmer.</p> <p>13 And then with increasing thickness, the 14 brightness will be going up, up until it reaches 15 full capacity. I mean, beyond which it cannot get 16 any brighter. And then there might be some 17 influence with light transmission and so forth 18 there so...</p> <p>19 Q. Okay. I think I understand, thank 20 you.</p> <p>21 A. But these sections I cut all at 22 four microns. All tissue within the one section is 23 exactly the same thickness.</p> <p>24 Q. Not if it's not cut at a 90-degree 25 angle, right?</p>

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<p>1 A. No, it's all four microns.</p> <p>2 Q. If the material is oriented at an</p> <p>3 angle, and not completely 90 degrees --</p> <p>4 A. It's still four microns.</p> <p>5 Q. -- to the knife --</p> <p>6 A. It's four microns. Can I draw it?</p> <p>7 Q. It's a three-dimensional space,</p> <p>8 though.</p> <p>9 A. No, it's a slice. So if you get</p> <p>10 slice like this, four microns. If you get slice</p> <p>11 like this, four microns. If you get slice like</p> <p>12 this, it's oblique, it's still four microns.</p> <p>13 Q. But the way the material is angled</p> <p>14 within the specimen is tilted?</p> <p>15 A. Yes. But it's still four microns</p> <p>16 thickness. The cross section is four microns</p> <p>17 thick, it doesn't matter what orientation, it's</p> <p>18 still four microns. Doesn't matter how you're in</p> <p>19 it, four microns. It's like a salami.</p> <p>20 Q. But if you look at it from looking</p> <p>21 up, you would be looking through less material on</p> <p>22 the far edge of the material if it was oriented</p> <p>23 sideways?</p> <p>24 A. Or the very edge, the very tip of</p> <p>25 this, yes. It will be somewhat different, yes.</p>	<p>1 And in none of these figures do we see</p> <p>2 the entire circumference of the mesh filament, do</p> <p>3 we?</p> <p>4 A. No, because it doesn't fit. Well,</p> <p>5 the thickness of this degraded layer is anywhere</p> <p>6 between two to six microns. Filament is up to</p> <p>7 here. It wouldn't fit.</p> <p>8 Q. Okay. So in the -- at the level</p> <p>9 of magnification that you need to view this narrow</p> <p>10 margin, what you call the degraded bark, you're not</p> <p>11 able to capture the entire circumference of the</p> <p>12 mesh filament in your imaging?</p> <p>13 A. Yes. This magnification size of</p> <p>14 filament is much larger, several pages larger. In</p> <p>15 some lower magnification, you can still see the</p> <p>16 degraded layer, but it's much less details.</p> <p>17 Q. One question I had was how you're</p> <p>18 able to tell that there isn't tissue interposed</p> <p>19 over the edge of the filament, and your eye,</p> <p>20 through the microscope.</p> <p>21 So if you're able to answer that, if</p> <p>22 not I can rephrase.</p> <p>23 A. How do I see if there's no tissue</p> <p>24 overlapping with the filament? Sometimes it is,</p> <p>25 just play with focus. Because it goes like this.</p>
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<p>1 Q. Okay, thank you. Thank you.</p> <p>2 THE VIDEOGRAPHER: Excuse me, Counsel.</p> <p>3 I have to change the tape.</p> <p>4 MS. BYARD: Perfect, let's take a</p> <p>5 break.</p> <p>6 THE VIDEOGRAPHER: This marks the end</p> <p>7 of media number three in the deposition of</p> <p>8 Dr. Vladimir Iakovlev.</p> <p>9 We are going off the record at</p> <p>10 5:28 p.m.</p> <p>11 -- RECESS AT 5:28 --</p> <p>12 -- UPON RESUMING AT 5:38 --</p> <p>13 THE VIDEOGRAPHER: Here begins media</p> <p>14 number four in the deposition of Dr. Vladimir</p> <p>15 Iakovlev.</p> <p>16 We're back on the record at 5:38 p.m.</p> <p>17 BY MS. BYARD:</p> <p>18 Q. Doctor, I have some relatively</p> <p>19 straightforward questions about the figures in your</p> <p>20 report related to paragraph 6. If you wouldn't</p> <p>21 mind turning with me to Figure 9C.</p> <p>22 A. What page number?</p> <p>23 Q. It's on page 33, sir. And I</p> <p>24 guess, really, this question refers to 9, 9A, 9B,</p> <p>25 9C, really all the way through to 16.</p>	<p>1 It's a different plane of focus, so you cannot</p> <p>2 focus on exactly the same. Even within four</p> <p>3 microns, you can focus only within very narrow</p> <p>4 range.</p> <p>5 So, essentially, you're looking at the</p> <p>6 slice which is much thinner than four microns.</p> <p>7 Probably you'll be in the focus of a range of one</p> <p>8 micron thickness only. The rest will be blurred.</p> <p>9 Like this picture, you mentioned 32.</p> <p>10 You see this is completely blurred. And it's</p> <p>11 probably just one micron deeper than this part.</p> <p>12 It's different plane, and it's out of focus, and</p> <p>13 then you don't see any details. Little further</p> <p>14 down, it will be just pink haze, from the breakoff.</p> <p>15 Q. Okay. So in order to focus in on</p> <p>16 what you call the degraded bark, you have to focus</p> <p>17 in at a level where you are assured you're looking</p> <p>18 past the tissue?</p> <p>19 A. What do you mean, where it overlaps?</p> <p>20 Q. (Nods.)</p> <p>21 A. Yes. I mean, I can even see -- I</p> <p>22 can focus on different layers of degraded material.</p> <p>23 On deeper, some more superficial, because focusing</p> <p>24 depth is very narrow. As I said, within one micron --</p> <p>25 with that magnification, it's very shallow.</p>

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<p>1 Q. You would agree, though, that it</p> <p>2 is typical for there to be some tissue overlapping</p> <p>3 the circumference of the mesh filament on cross</p> <p>4 section?</p> <p>5 A. No. Typical is contraction, so</p> <p>6 tissue contracts during dehydration, it splits and</p> <p>7 goes away. Usually, the way when it overlaps, when</p> <p>8 it lifts up, floats and sits on tissue.</p> <p>9 But if it sits in situ, this should</p> <p>10 contract and retracts. So usually there is a</p> <p>11 separation. Sometimes there is not on edges, but</p> <p>12 overlap with the tissue is least common phenomena.</p> <p>13 Again, any overlap in the field will</p> <p>14 not be visible because of the depth of sharpness.</p> <p>15 I can focus on the very narrow depth. You can have</p> <p>16 15-microns difference with different layers, and if</p> <p>17 you have enough light which is passing through, you</p> <p>18 can gradually see layer by layer, and steady</p> <p>19 details within these 15 microns.</p> <p>20 Q. Have you continued soaking that</p> <p>21 virgin mesh or other virgin mesh samples in</p> <p>22 formalin?</p> <p>23 A. Yeah, I have some still sitting in</p> <p>24 formalin.</p> <p>25 Q. When was the last time that you</p>	<p>1 THE WITNESS: I'm telling you.</p> <p>2 BY MS. BYARD:</p> <p>3 Q. You're telling me, but I don't</p> <p>4 have the underlying data, right?</p> <p>5 MR. ORENT: Objection.</p> <p>6 THE WITNESS: That's correct.</p> <p>7 BY MS. BYARD:</p> <p>8 Q. Okay. Looking at paragraph 7 of</p> <p>9 your report, sir, on page 6. You write that:</p> <p>10 "The published literature</p> <p>11 indicates that the main</p> <p>12 complications of transvaginal mesh</p> <p>13 devices leading to mesh excision are</p> <p>14 chronic pelvic pain, pain with</p> <p>15 intercourse, parenthesis, [dyspareunia],</p> <p>16 de novo, worsening urinary symptoms</p> <p>17 and mucosal erosion, parenthesis,</p> <p>18 [mesh exposure]."</p> <p>19 Which articles are you relying on for</p> <p>20 that statement?</p> <p>21 A. Clinical.</p> <p>22 Q. Are there articles in your list of</p> <p>23 materials reviewed that you can point me to for</p> <p>24 that proposition?</p> <p>25 A. The regular complications? Yes.</p>
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<p>1 examined them for degradation?</p> <p>2 A. Sometime during summer. But</p> <p>3 sometimes I completely use up the sample, so I have</p> <p>4 to start the process again, so it's not -- the</p> <p>5 first mesh was exposed, I think last fall. But I</p> <p>6 don't think I have samples from that time, so there</p> <p>7 will be -- I just have dates written on the jars,</p> <p>8 so...</p> <p>9 Q. Okay. And the longest still it's</p> <p>10 been in formalin is four months?</p> <p>11 A. Four months. It's way beyond the --</p> <p>12 when I was writing this manuscript, we talk about,</p> <p>13 about 25 percent of the samples had exposure time</p> <p>14 less than a month. And about 8 or 10 percent of</p> <p>15 the specimens I examined had exposure to formalin</p> <p>16 less than 72 hours. And they still showed the same</p> <p>17 degradation layer, so...</p> <p>18 Q. And you're referring to one of</p> <p>19 your published studies?</p> <p>20 A. In preparation. But I'm just</p> <p>21 telling you the date. So four months is overkill</p> <p>22 by many fold.</p> <p>23 Q. Okay. And that's not data that we</p> <p>24 have yet, right?</p> <p>25 MR. ORENT: Objection.</p>	<p>1 I mean, there are some clinical articles there.</p> <p>2 Q. Any in particular that you would</p> <p>3 cite for support for that proposition?</p> <p>4 A. I would have to check these papers</p> <p>5 again, sorry. Because it's been quite sometime. I</p> <p>6 don't remember exactly which article specifies,</p> <p>7 but...</p> <p>8 Q. Now in contrast, your data that</p> <p>9 you publish with Dr. Carey indicated that the</p> <p>10 number one reason for excision in the samples that</p> <p>11 you reviewed there, were for exposure, correct?</p> <p>12 A. You mean mucosal exposure? Yes.</p> <p>13 Q. Okay. If I were to ask you what</p> <p>14 the rate in the medical and scientific literature</p> <p>15 of excision for dyspareunia was, compared to the</p> <p>16 rate of excision for dyspareunia in your 120</p> <p>17 specimens, you couldn't cite me those numbers,</p> <p>18 could you?</p> <p>19 A. I would have to go through papers</p> <p>20 and -- the rate will be different in each paper,</p> <p>21 and there is no such thing as the same rates. So</p> <p>22 there will be a range of rates.</p> <p>23 Q. And that analysis hasn't been</p> <p>24 completed, has it?</p> <p>25 MR. ORENT: Objection.</p>

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<p>1 THE WITNESS: What do you mean, which</p> <p>2 analysis?</p> <p>3 BY MS. BYARD:</p> <p>4 Q. Comparing the range of reported</p> <p>5 rates of dyspareunia as the reason for excision in</p> <p>6 the published literature, with the rate of excision</p> <p>7 for dyspareunia in your sample size of 120</p> <p>8 specimens?</p> <p>9 A. If I published this comparison?</p> <p>10 No, I have not published this comparison.</p> <p>11 Q. And you haven't done that</p> <p>12 comparison yet, either, right?</p> <p>13 A. Well, roughly I estimated.</p> <p>14 Because you can see in the papers what is</p> <p>15 percentage of those excised for -- where is it?</p> <p>16 Q. It was Exhibit 1198.</p> <p>17 A. So if we split now, see I have --</p> <p>18 I had 67 percent exposure, 56 percent pain, and</p> <p>19 overlap between them, 33 percent.</p> <p>20 Q. That was for 24 specimens, though?</p> <p>21 A. Yeah, that was a pool size in</p> <p>22 that. If you're asking for complete set, no. And</p> <p>23 this set is growing every day, I mean I'm receiving</p> <p>24 samples, so...</p> <p>25 Q. So for the set of 120 specimens,</p>	<p>1 A. No, but --</p> <p>2 Q. Okay, thank you.</p> <p>3 You write here in paragraph 7, that</p> <p>4 this is consistent with random sampling since the</p> <p>5 samples had variable sources and manufacturers; do</p> <p>6 you see that?</p> <p>7 A. Yes, they were coming from</p> <p>8 different sources, from -- they were of different</p> <p>9 manufacturers. They were excised for different</p> <p>10 reasons. The range of patient demographics was</p> <p>11 large.</p> <p>12 Q. You haven't set up a registry,</p> <p>13 though, for mesh excisions in the transvaginal mesh</p> <p>14 example like you have for hernia mesh in your study</p> <p>15 with Dr. Bendavid, right?</p> <p>16 A. No. Those samples are obtained</p> <p>17 prospectively, these samples were obtained</p> <p>18 retrospectively.</p> <p>19 Q. And the sources were threefold.</p> <p>20 They were either St. Michael's, they were other</p> <p>21 hospitals, and they were from the Plaintiffs'</p> <p>22 lawyers through various --</p> <p>23 A. But when they come from lawyers,</p> <p>24 they're not coming from one specific individual.</p> <p>25 They're coming from different excising surgeons,</p>
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<p>1 you can't tell me what the rate of complications</p> <p>2 were prompting the revision surgery, right?</p> <p>3 MR. ORENT: Objection.</p> <p>4 THE WITNESS: I can estimate the range</p> <p>5 anywhere from 30 to 50 percent, somewhere. It</p> <p>6 depends on the -- I mean, again...</p> <p>7 BY MS. BYARD:</p> <p>8 Q. You don't have those numbers or</p> <p>9 those statistics analyzed yet, correct?</p> <p>10 A. Not for the total number of</p> <p>11 specimens I received by today. I mean, I</p> <p>12 initially, as for this study, I did analysis; and</p> <p>13 then I think I did analysis sometime in between.</p> <p>14 But I mean, I have not done it like yesterday --</p> <p>15 Q. Okay.</p> <p>16 A. -- for all specimens I receive.</p> <p>17 Q. The numbers you can quote for me</p> <p>18 today are from these 24 samples that are -- that</p> <p>19 have been analyzed in the study that you published</p> <p>20 with Dr. Carey that's Exhibit 1198?</p> <p>21 A. This is just the paper in front of</p> <p>22 me. I might have the number on the spreadsheet in</p> <p>23 my log of specimens.</p> <p>24 Q. Okay. And they're not set forth</p> <p>25 in your report, right?</p>	<p>1 different states, different hospitals of -- you</p> <p>2 make it sound as if lawyers, just one person, one</p> <p>3 clinician and one lab, no. It's all over, you know</p> <p>4 that.</p> <p>5 Q. And your research on hernia repair</p> <p>6 mesh, you didn't receive samples from Plaintiffs'</p> <p>7 lawyers, right?</p> <p>8 MR. ORENT: Objection.</p> <p>9 THE WITNESS: Which research?</p> <p>10 BY MS. BYARD:</p> <p>11 Q. The study that you published with</p> <p>12 Dr. Bendavid?</p> <p>13 A. The SIN paper? No, there was no</p> <p>14 litigation cases in this paper.</p> <p>15 Q. Paragraph 8 continues:</p> <p>16 "Pain is reported as the most</p> <p>17 frequent complication of a mesh</p> <p>18 procedure in published literature</p> <p>19 and in the clinical records that I</p> <p>20 reviewed."</p> <p>21 Do you see that?</p> <p>22 A. That's correct.</p> <p>23 Q. Which study are you relying on for</p> <p>24 that proposition?</p> <p>25 A. There were a number of studies</p>

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<p>1 where the pain was higher. Sometimes there are 2 other -- pain is a very subjective subject, and 3 sometimes it's not assessed. There is no primary 4 goal of the studies to assess pain, so they just 5 provide statistics. When the study is more focused 6 on pain, the numbers might be higher. So it's a 7 range.</p> <p>8 Q. And the studies that you reviewed, 9 what was the range of reported pain as a reason for 10 excision?</p> <p>11 A. You mean percentage-wise? I don't 12 remember now, but I mean there were a number of 13 studies which showed pain as a first -- the number 14 was higher, higher than anything else.</p> <p>15 Q. Are you referring to hernia mesh 16 literature or transvaginal mesh literature?</p> <p>17 A. Transvaginal mesh. And this is 18 just complication, it's not a reason for excision.</p> <p>19 You see, if you read this, "the pain is 20 the most frequent complication." So if you go 21 through it, it may go up to 30 percent, even higher 22 in some literature. Some literature it goes -- in 23 some publications it goes lower.</p> <p>24 Q. As you were reviewing the medical 25 literature on complications of transvaginal mesh,</p>	<p>1 entrapped in tissue that was never exposed to mesh, 2 right?</p> <p>3 A. No, this is not correct. If you 4 take tissue as a general, there cannot be 5 entrapment because there is no tight area. 6 Entrapment happens in specific anatomical locations 7 where there is a tunnel, or there is a compartment. 8 I'm talking about normal, spontaneously occurring 9 sort of entrapment or tunnel syndromes.</p> <p>10 This is not happening in, in tissue as 11 we talk about it. It's like a tunnel, usually 12 surrounded by some kind of winding, synovial 13 winding of the place, tight spot where nerves pass 14 through.</p> <p>15 Q. So if I understand your testimony 16 correctly, you can have nerve entrapment in the 17 body, even if there's not any mesh, against certain 18 anatomical structures, or tunnels, or compartments 19 as you've described it?</p> <p>20 MR. ORENT: Objection.</p> <p>21 THE WITNESS: I mean, usually there is 22 some degree of pathology called changes in the 23 area. It's not normal to have an entrapment 24 syndrome. 25</p>
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<p>1 did you keep any notes on what the reported rate of 2 complication was for different symptoms?</p> <p>3 A. No. Because I wasn't writing a 4 paper for that specific, it was just a memory of my 5 understanding.</p> <p>6 Q. Do you agree that innervated 7 tissue, anywhere in the body, can be subject to 8 potential pain mechanisms of direct irritation to 9 the nerves?</p> <p>10 A. Yes.</p> <p>11 Q. Entrapment?</p> <p>12 A. Entrapment in normal tissue?</p> <p>13 Q. (Nods.)</p> <p>14 A. If entrapment happens, it's 15 abnormal. I mean, if you assume that there are 16 places in the body which can cause entrapment 17 syndromes, the entrapment itself becomes abnormal.</p> <p>18 Q. Sure. And I'm talking about 19 innervated tissue anywhere in the body can present 20 a finding of entrapment on histological examination?</p> <p>21 A. No, it cannot. Entrapment, in 22 normal circumstances, occurs in tight spaces where 23 nerves pass by. So these are very specific 24 anatomical locations.</p> <p>25 Q. It's possible for nerves to be</p>	<p>1 BY MS. BYARD:</p> <p>2 Q. Sure. But what I want to focus on 3 here are abnormal pathological findings that are 4 mechanisms for pain.</p> <p>5 And I want to focus on abnormal 6 pathological findings that are mechanisms for pain, 7 and whether those mechanisms exist without mesh?</p> <p>8 A. In the vaginal area, no. There 9 are no anatomical locations, or specific anatomical 10 structures to cause nerve entrapment without mesh.</p> <p>11 Q. Without mesh you can never have 12 nerve entrapment in the vagina; is that your 13 testimony?</p> <p>14 MR. ORENT: Objection.</p> <p>15 THE WITNESS: If there is no mesh and 16 there is no other pathological condition, like a 17 tumor or something else, it cannot happen.</p> <p>18 BY MS. BYARD:</p> <p>19 Q. Okay. So if there is a tumor you 20 can have nerve entrapment?</p> <p>21 A. That's correct. With tumor, there 22 will be little bit different mechanisms. But there 23 will be effected nerves.</p> <p>24 Q. Okay. If there's another foreign 25 body besides the mesh in the vagina, there could be</p>

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<p>1 nerve entrapment?</p> <p>2 A. If there is foreign body with</p> <p>3 compartment.</p> <p>4 Q. Okay. Innervated tissue anywhere</p> <p>5 in the body can be exposed to pain mechanisms that</p> <p>6 are inflammatory in nature, right?</p> <p>7 A. Spontaneously occurring</p> <p>8 inflammatory conditions, that's what you mean?</p> <p>9 Q. Any sort of inflammatory mechanism</p> <p>10 of pain.</p> <p>11 MR. ORENT: Objection. Vague.</p> <p>12 THE WITNESS: As we stated before, as I</p> <p>13 stated before, inflammation alters sensitivity</p> <p>14 threshold.</p> <p>15 So any inflammation can build up, so</p> <p>16 the basis for pain, or cause pain if it's</p> <p>17 sufficiently high enough.</p> <p>18 BY MS. BYARD:</p> <p>19 Q. Can compression by edema act as a</p> <p>20 mechanism for pain for tissue with nerve ingrowth,</p> <p>21 even when there is no mesh present?</p> <p>22 A. If it's enclosed compartment --</p> <p>23 well, see, edema, if there's no walls of a</p> <p>24 compartment, edema will expand further. If it</p> <p>25 grows rapidly, it may cause some discomfort or</p>	<p>1 BY MS. BYARD:</p> <p>2 Q. That's a very fair point. The</p> <p>3 entire reason you have identified these potential</p> <p>4 pain mechanisms with mesh, is because these are</p> <p>5 well understood mechanisms for pain in the</p> <p>6 literature, apart from any findings related to</p> <p>7 mesh, correct?</p> <p>8 A. Yes. But, when I examine</p> <p>9 specimens, I don't find anything else except for</p> <p>10 changes related to the mesh. I don't find the</p> <p>11 tumor, I don't find myositis, which can cause</p> <p>12 necrosis of the vessels.</p> <p>13 So, part of my job as a pathologist, is</p> <p>14 to rule out other conditions. And then I see only</p> <p>15 changes which are related to the mesh.</p> <p>16 Q. As a part of your practice,</p> <p>17 though, in the litigation context, if you receive a</p> <p>18 specimen that's a uterus, and clearly not mesh, you</p> <p>19 don't examine it?</p> <p>20 A. I do examine it.</p> <p>21 Q. You do?</p> <p>22 A. I do, yeah. If I receive a</p> <p>23 specimen, I look through the microscope.</p> <p>24 Q. And do those findings make their</p> <p>25 way into a report that's disclosed to us?</p>
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<p>1 pain. If there is no compartment, edema will --</p> <p>2 and if it goes slowly, it will just be painless</p> <p>3 edema. But the problems are when the edema goes</p> <p>4 faster; or, if it occurs in enclosed space.</p> <p>5 So you need to set some pathological</p> <p>6 condition. To form this walls of compartment, or</p> <p>7 place foreign body, and then, to cause edema. And</p> <p>8 then edema would occur in an enclosed compartment.</p> <p>9 Q. So in certain pathological</p> <p>10 conditions, in the absence of mesh, compression by</p> <p>11 edema can cause pain?</p> <p>12 MR. ORENT: Objection.</p> <p>13 THE WITNESS: That's correct.</p> <p>14 BY MS. BYARD:</p> <p>15 Q. Even in the absence of mesh?</p> <p>16 A. Yes. That's why I know that edema</p> <p>17 can cause pain, because there are conditions which</p> <p>18 cause pain through the swelling.</p> <p>19 Q. Thank you.</p> <p>20 Is the same true for ischemia?</p> <p>21 MR. ORENT: Objection.</p> <p>22 THE WITNESS: For ischemia, yes.</p> <p>23 Again, that's why I can state that this has</p> <p>24 probability to cause pain, because we know that it</p> <p>25 causes pain in other parts of the body.</p>	<p>1 MR. ORENT: Objection.</p> <p>2 THE WITNESS: I don't remember now.</p> <p>3 BY MS. BYARD:</p> <p>4 Q. Withdrawn.</p> <p>5 In the absence of mesh, there can also</p> <p>6 be mechanical irritation of receptors, right?</p> <p>7 A. Mechanical, if it's normal degree</p> <p>8 of stimulation, it will not cause pain. If it's</p> <p>9 abnormal degree, if it's high enough, it will cause</p> <p>10 pain. That's how --</p> <p>11 Q. Yes. Exactly.</p> <p>12 A. -- take a hammer and then it will,</p> <p>13 it will hurt without mesh.</p> <p>14 Q. Okay.</p> <p>15 A. But if you just press it with your</p> <p>16 finger, just feel the touch.</p> <p>17 Q. Ending paragraph 8 you write:</p> <p>18 "These findings correlate with</p> <p>19 clinical findings of pain, particularly</p> <p>20 chronic pain in women."</p> <p>21 Do you see that?</p> <p>22 A. Yes.</p> <p>23 Q. What's the difference, in your</p> <p>24 understanding, your vocabulary, between</p> <p>25 "correlation" and "causation"?</p>

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<p>1 A. Clinical pathological correlation. 2 So when I receive a specimen, and described as 3 removed for reasons of pain, as I said, I examine 4 it for pathological findings, I rule out natural 5 occurring non-mesh-related conditions, then examine 6 what happened in the mesh. So, that's what it 7 meant. 8 Q. Okay. And so it's not as if 9 you're looking at a pathological -- a pathology 10 slide and saying, "aha, it was this edema that 11 caused all this pain that she reported." Right? 12 MR. ORENT: Objection. 13 THE WITNESS: See, when I receive a 14 specimen, I know that there was pain, and it's 15 indicated that -- sometimes I look at the history 16 later. So I know that there was pain, and I do 17 clinical pathology called correlation. 18 You cannot -- it's not a game, I mean, 19 it's a diagnostic process. You have to take all 20 information available to you and then correlate. 21 Clinical investigation was done because 22 of pain, they narrowed down problem to the excised 23 mesh, I received a specimen. So I already know 24 that there was a problem, complication, that's why 25 it was excised.</p>	<p>1 excise, you cause damage, and there is more 2 scarring. Because when you do multiple procedures 3 throughout, the scar is there. So there might be 4 some residual changes in there. So the initial 5 cause of these changes would be still mesh. 6 How do you separate all of this? And 7 how do you ascertain completeness of excision? How 8 they are certain that the postexcision changes are 9 not residual changes which occurred while mesh was 10 there? This is difficult. 11 BY MS. BYARD: 12 Q. You would agree that correlation 13 isn't causation, though, wouldn't you? 14 MR. ORENT: Objection. 15 THE WITNESS: See, when you use 16 causation, do you use it in -- let me ask, I mean, 17 just to clarify this. 18 When you use word "causation," do you 19 mean "prediction"? Or correlation of clinical 20 picture with the pathological findings? 21 BY MS. BYARD: 22 Q. I guess maybe the better way to 23 ask it is that the word you used here was 24 "correlate," right? Not "cause"? 25 A. And I explain it. Correlation is</p>
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<p>1 Then I try to figure out what was 2 causing it, what is abnormal in the specimen which 3 was removed as a part of treatment of the 4 complications, or patient's symptoms. And then I 5 rule out naturally occurring, I don't see it, and 6 then I see this. 7 And then, if somebody tells me, "I have 8 a pain." And I examine the specimen, and there is 9 mesh with edema, with nerve ingrowth, this is the 10 cause of pain. Because there is nothing else in 11 the specimen which would explain it. 12 BY MS. BYARD: 13 Q. Now, if that patient's pain 14 continues after that mesh is excised, you can then 15 agree with me that the edema, or the foreign body 16 inflammation can no longer be considered the cause 17 of those symptoms, right? 18 MR. ORENT: Objection. 19 THE WITNESS: If entire mesh is excised 20 without damage to the tissue, which is 21 hypothetical, I don't think most of the meshes can 22 be excised completely, or completeness of excision 23 can be as certain. So the first difficult part of 24 the statement. 25 The second difficulty is that when you</p>	<p>1 clinical pathology calculation. Patient comes with 2 complication, symptoms. So that's where clinical 3 part comes in. And there's investigation, there's 4 narrowing down, and then I examine the specimen to 5 see what is abnormal in it. So this is diagnostic 6 process and treatment process. 7 If you're talking about prediction, 8 what can happen in the future is something 9 occurring now, that's not how medicine works. 10 So the correlation here, correlation 11 between what was clinically seen abnormal, and what 12 I see in the microscope. 13 Q. So you're relying, in large part 14 then, on the clinical determination that's made by 15 the treating physician, that the doctor and the 16 patient should at least try to excise the mesh to 17 address the patient's symptoms, right? 18 A. Yes. 19 Q. You also write that: 20 "Placement of vaginal tissue --" 21 and I'm looking at paragraph 9 now, 22 Doctor. "-- is associated with a 23 higher risk of chronic pain issues 24 than the placement of abdominal mesh -- 25 abdominal hernia mesh." Excuse me.</p>

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<p>1 A. That's correct.</p> <p>2 Q. And what literature are you citing</p> <p>3 for that proposition?</p> <p>4 A. Again, clinical literature. Being</p> <p>5 in the hernia is lower, somewhere in the range from</p> <p>6 about 10 percent or so, but for transvaginal meshes</p> <p>7 it can go up to 30 percent.</p> <p>8 Again, it's very, very difficult to</p> <p>9 compare the studies, because they use different</p> <p>10 questionnaires and different approaches.</p> <p>11 Q. And are you talking about rates of</p> <p>12 chronic pain as a complication overall, or is it</p> <p>13 complication leading to excision in this statement?</p> <p>14 A. Complication overall.</p> <p>15 Q. We talked earlier about how the</p> <p>16 vagina compared to the abdominal wall, as a</p> <p>17 nerve-rich environment, right?</p> <p>18 A. Yes.</p> <p>19 Q. And you would also agree with me</p> <p>20 then, that the vagina as an area of the body is</p> <p>21 associated with a higher risk of chronic pain</p> <p>22 compared to the abdomen, because it is a more</p> <p>23 nerve-rich environment, right?</p> <p>24 A. Yes.</p> <p>25 Q. And that's true in the absence of</p>	<p>1 it's personal experience of each individual.</p> <p>2 But the studies who studied further,</p> <p>3 how it happens with inflammatory mediators and</p> <p>4 other things, yeah, they are there.</p> <p>5 Q. There are studies that exist?</p> <p>6 A. There should be at least in that.</p> <p>7 Q. Okay. Are there studies looking</p> <p>8 more specifically at inflammation and foreign body</p> <p>9 reaction in the presence of mesh, and whether that</p> <p>10 heightens the sensitivity threshold of pain</p> <p>11 receptors?</p> <p>12 A. It's almost like narrowing down</p> <p>13 something to a specific area, like could there be a</p> <p>14 doctor for a little right finger.</p> <p>15 Q. The answer is, "no," right?</p> <p>16 A. There are studies which study</p> <p>17 inflammation, in general. I mean, there's a</p> <p>18 physician or any thinking person, you can apply it</p> <p>19 to any areas so...</p> <p>20 Q. So the answer to my question is,</p> <p>21 no, the literature doesn't get that specific,</p> <p>22 right?</p> <p>23 MR. ORENT: Objection.</p> <p>24 THE WITNESS: Not that narrow.</p> <p>25</p>
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<p>1 mesh, too, isn't it?</p> <p>2 A. Yes.</p> <p>3 Q. You conclude paragraph 10, with</p> <p>4 the statement that:</p> <p>5 "It is well established that</p> <p>6 inflamed tissue alters the</p> <p>7 sensitivity threshold of pain</p> <p>8 receptors."</p> <p>9 A. Yes.</p> <p>10 Q. Are you with me?</p> <p>11 A. Yes.</p> <p>12 Q. Is there a specific study or</p> <p>13 studies that you're relying on in support of that</p> <p>14 proposition?</p> <p>15 A. There are studies, I mean, but you</p> <p>16 probably experience inflammation yourself during</p> <p>17 your lifetime, everybody does. So do you need a</p> <p>18 study to learn this?</p> <p>19 Q. Leave me out of it. Let's leave</p> <p>20 me out of it.</p> <p>21 Is there, so you can point me to, though?</p> <p>22 A. I mean, everybody experience</p> <p>23 inflammation in their lifetime. Everybody knows.</p> <p>24 And there are studies which are studying mechanisms</p> <p>25 of that. The fact itself is not even commonsense,</p>	<p>1 BY MS. BYARD:</p> <p>2 Q. Thank you. Let's look at page 8,</p> <p>3 please.</p> <p>4 I assume your response will be the</p> <p>5 same, but with respect to transvaginal mesh, or</p> <p>6 really just polypropylene mesh in general, you</p> <p>7 can't point me to a specific study showing that the</p> <p>8 pain caused by swelling is present in amplified</p> <p>9 state, because of the compartments of mesh, right?</p> <p>10 MR. ORENT: Objection.</p> <p>11 THE WITNESS: Specific studies? I</p> <p>12 mean, we described it in our paper. But</p> <p>13 specifically that the edema was studied in meshes,</p> <p>14 I cannot -- there are no studies which specifically</p> <p>15 studied edema in meshes.</p> <p>16 BY MS. BYARD:</p> <p>17 Q. And you would concede that there</p> <p>18 could be women with edema present in the presence</p> <p>19 of their mesh, who don't complain of pain, right?</p> <p>20 A. It's possible that there is edema</p> <p>21 within some compartments, and it doesn't cause</p> <p>22 pain. Because it's a complex process, you might</p> <p>23 need several factors which play together to cause</p> <p>24 pain. Some people not sensitive, some people don't</p> <p>25 complain, so this is not black and white.</p>

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<p>1 Q. Okay. And the same thing is true</p> <p>2 for scar tissue, right? We know that all mesh will</p> <p>3 be present with scar tissue, and yet not all women</p> <p>4 with mesh experience pain?</p> <p>5 MR. ORENT: Objection.</p> <p>6 THE WITNESS: See, this is difficult.</p> <p>7 Because I don't actually have the specimens from</p> <p>8 women who for sure didn't experience pain, or</p> <p>9 didn't experience any complications. This would be</p> <p>10 an autopsy series, which is difficult.</p> <p>11 So all cases I receive, they have</p> <p>12 complications, all have scars. If those who never</p> <p>13 have any complications, how much of scarring --</p> <p>14 there would be scar, if there is a different extent</p> <p>15 of scarring, I don't know.</p> <p>16 BY MS. BYARD:</p> <p>17 Q. In fact, let me rephrase that.</p> <p>18 Strike that.</p> <p>19 The fact that women can have scarring</p> <p>20 because of mesh, but not experience pain, tends to</p> <p>21 call into question, the association between the</p> <p>22 presence of that scar tissue around the mesh and</p> <p>23 pain, doesn't it?</p> <p>24 A. It contributes. The scar itself,</p> <p>25 wouldn't be a problem. But scar with mesh, with</p>	<p>1 A. Possibly in some locations, yes.</p> <p>2 But when I see it in the meshes, everything outside</p> <p>3 of mesh is collapsed, and then vessels in the folds</p> <p>4 of the mesh are dilated.</p> <p>5 So, therefore, I have internal control.</p> <p>6 I see what is outside of the mesh and I see what is</p> <p>7 inside of the mesh, it's different.</p> <p>8 Q. You've looked at about 120</p> <p>9 specimens of transvaginal mesh at the time that you</p> <p>10 authored your report.</p> <p>11 Do you have any statistics that you can</p> <p>12 cite for me for the rate of dilated and congested</p> <p>13 vessels in non-scarred vaginal tissue that you have</p> <p>14 examined in your course as a pathologist.</p> <p>15 A. See, normally, you don't see</p> <p>16 congestion. Congestion of the vessels is not</p> <p>17 normal. I mean, there has to be something which is</p> <p>18 causing it. So if it's normal tissue -- if I quote</p> <p>19 it "normal," it means that there are no</p> <p>20 pathological findings.</p> <p>21 If I see congestion, and some other</p> <p>22 changes, I mean, this would not be perfectly</p> <p>23 abnormal. I mean, there might be some bleeding due</p> <p>24 to surgery or something else.</p> <p>25 Q. You can't quote a rate then</p>
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<p>1 innervation, with connection to other areas, then</p> <p>2 the whole complex of changes, this leads to pain.</p> <p>3 Q. Well, from your research you've</p> <p>4 concluded that all mesh will have innervation,</p> <p>5 right?</p> <p>6 A. Transvaginal?</p> <p>7 Q. (Nods).</p> <p>8 A. Yes. Because all meshes I</p> <p>9 received. But again, I don't know what is</p> <p>10 happening in those meshes which don't have any</p> <p>11 complications, or patients don't complain to a</p> <p>12 degree that the mesh is excised.</p> <p>13 Q. Okay, thank you.</p> <p>14 Have you heard of a condition called</p> <p>15 pelvic floor congestion syndrome?</p> <p>16 A. Not specifically.</p> <p>17 Q. Do you know if there are ways to</p> <p>18 measure blood flow in the pelvis?</p> <p>19 A. Dopplar.</p> <p>20 Q. And you haven't looked at studies</p> <p>21 on that issue, have you?</p> <p>22 A. On Dopplar studies, no.</p> <p>23 Q. Would you agree with me that blood</p> <p>24 vessels can become dilated and congested in the</p> <p>25 vagina and surrounding area in the absence of mesh?</p>	<p>1 because you don't see it typically; is that what</p> <p>2 you're saying?</p> <p>3 A. What do you mean, rate of what</p> <p>4 happens with --</p> <p>5 Q. How often those findings are</p> <p>6 present in non-mesh vaginal specimens?</p> <p>7 A. I don't see it.</p> <p>8 MR. ORENT: Objection.</p> <p>9 THE WITNESS: I don't see it normally.</p> <p>10 BY MS. BYARD:</p> <p>11 Q. And I'm using the word "normally"</p> <p>12 to describe "commonly". I'm asking about abnormal</p> <p>13 pathological findings.</p> <p>14 A. I don't understand exactly. If</p> <p>15 you want me to tell if I see the difference what is</p> <p>16 inside the mesh of tissue, and what is outside on</p> <p>17 the mesh, either in the specimen of mesh or</p> <p>18 specimens without the mesh; there is a marked</p> <p>19 difference between what is inside the mesh and</p> <p>20 outside the mesh.</p> <p>21 Q. And I'm thinking about patients</p> <p>22 who undergo excisions who have never had mesh. Not</p> <p>23 variation within a specimen.</p> <p>24 MR. ORENT: Objection.</p> <p>25 THE WITNESS: I don't see any</p>

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<p>1 congestion. If it's a healthy, elective procedure 2 for hysterectomy, when they do some trimming of the 3 vagina, and then they get vaginal cuff, there is no 4 congestion. 5 BY MS. BYARD: 6 Q. Okay. 7 A. No edema, no congestion, no 8 inflammation, is pristine tissue. 9 Q. And that's for a patient who's 10 undergoing surgery electively, not because the 11 uterus or surrounding organs, the ovaries, were 12 identified as being a potential cause of that 13 woman's complaints, right? 14 A. There are complaints. I mean, 15 there is a reason for hysterectomy. Usually it's 16 dysmenorrhea or just -- 17 Q. Heaviness? 18 A. Excessive bleeding in perimenopausal 19 periods, so they don't want to have -- to take 20 drugs, so... 21 Q. Okay. You write in paragraph 13 22 about muscle relationships with mesh; are you with 23 me? 24 A. Yes. 25 Q. Can striated muscle grow within</p>	<p>1 mesh, muscle contraction results in 2 pulling of the entire mesh." 3 Do you see that? 4 A. Yes. 5 Q. Can you point me to any published 6 articles that show muscle contraction pulling on 7 the mesh? 8 A. No, it has not been specifically 9 studied in that specific sequence as you word it. 10 Q. You could design an experiment 11 where you could look at muscle contraction in its 12 relationship to mesh, couldn't you? 13 A. What I do see, when I can tell you 14 that if the muscle strength is viable, so it's 15 contractile. Because see, with a muscle, if it 16 doesn't -- if it degenerates, it's not contract 17 anymore. 18 If it's healthy muscle, it will 19 contract. So those muscle fibers or bundles, I see 20 in the mesh, they're healthy. Therefore, they 21 contract. 22 Q. As far as how the mesh is then 23 pulled by that muscle contraction, you could design 24 an experiment, though, looking at, for instance, 25 3D ultrasound technology?</p>
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<p>1 the mesh structure? 2 A. That's a difficult question. 3 Technically, muscle itself cannot grow through 4 the -- or in large amount, cannot grow through 5 mesh. 6 So there has to be a combination of 7 either mesh placement into the muscle, which is 8 done, we know. Or migration of the mesh into the 9 muscle, and a degree of muscle regeneration in the 10 folds or in the -- so it would be a combination of 11 factors, how the mesh -- how the muscle strands 12 become inside the mesh pores or folds. 13 Q. And you can't say when you look at 14 a specimen, how that muscle and mesh got to where 15 they are? 16 A. Depends. In some specimens, the 17 mesh just cuts through the muscle, and you see the 18 trail of the muscle, it just sifts through it. 19 Then I can say for sure the mesh migrated into the 20 muscle, it left behind. But now muscle is 21 interrupt, because mesh just went through it. But 22 sometimes it's an array of different things, so I 23 don't know, I cannot tell. 24 Q. You write that: 25 "Where muscle is attached to</p>	<p>1 A. Oh, if the mesh is moving during 2 movements, and -- yeah, you can do it. I mean, you 3 can see -- well, as long as mesh is mobile. If 4 it's so tight that it's not mobile anymore, like if 5 it's saw it here in between pubic bones, then it 6 will not be mobile. But it doesn't allow -- that 7 muscle is trying to contract, it just cannot move 8 it anymore because it's so immobile. 9 Q. And you're talking about various 10 scenarios that you could understand based on your 11 training and experience, correct? 12 A. That's correct. 13 Q. You're not talking about findings 14 that you've seen based on an experiment using, for 15 instance, 3D ultrasound technology that you, 16 yourself, have performed, right? 17 A. No. I'm basing what I see on the 18 microscope. If it's healthy muscle, within the 19 mesh, completely surrounded by the mesh, it's 20 contraction will cause movement of the muscle. 21 Q. And you haven't tested your 22 hypothesis about how muscle contraction will 23 interact with mesh in living patients? 24 MR. ORENT: Objection. 25 THE WITNESS: It's not a hypothesis.</p>

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<p>1 This is my interpretation of the microscopic 2 findings, that's what I'm trained to do. Interpret 3 what I see in the microscope, so...</p> <p>4 BY MS. BYARD:</p> <p>5 Q. You haven't tested that finding in 6 living patients, right?</p> <p>7 MR. ORENT: I'm not sure if he was done 8 with his prior answer.</p> <p>9 BY MS. BYARD:</p> <p>10 Q. Oh, sorry.</p> <p>11 A. See, this is not my job, I mean, I 12 know what tissue does. So if a muscle is healthy, 13 it contracts. This is what we know based on -- 14 mesh, no mesh, we've known it for thousands of 15 years, muscle contracts. If it's healthy muscle, 16 it contracts. If it is in the mesh and completely 17 surrounded by the mesh, the contraction will pull. 18 So this is my interpretation as a pathologist.</p> <p>19 If I measured what the strength, what 20 the force it produces in that specific section, no, 21 but I don't have to. Because my job is 22 interpretation, and that is my interpretation.</p> <p>23 Q. Okay. So in answering my 24 question, have you tested this yourself in humans, 25 in living humans, your answer would be, "no"?</p>	<p>1 MR. ORENT: Objection.</p> <p>2 BY MS. BYARD:</p> <p>3 Q. -- right?</p> <p>4 A. That's correct.</p> <p>5 Q. There are ways to measure the 6 forces at work in the body, aren't there?</p> <p>7 A. You have to explain a little bit 8 more, what do you mean "forces in ways --"?</p> <p>9 Q. Well, there are ways that you 10 could measure, for instance, the intraabdominal 11 force placed on muscle through, through ultrasound 12 technology, can't you?</p> <p>13 MR. ORENT: Objection. Vague.</p> <p>14 THE WITNESS: I'm not sure if you can 15 use ultrasound to measure the force.</p> <p>16 For diagnostic purposes, I don't -- 17 well, I mean, first of all, I'm not sure if it can 18 be done. Second, I don't see diagnostic purpose, 19 and I certainly wouldn't expect it to be done for 20 diagnostic purposes.</p> <p>21 BY MS. BYARD:</p> <p>22 Q. Are you familiar with something 23 called "urodynamic testing"?</p> <p>24 A. Urodynamic is different.</p> <p>25 Q. How so?</p>
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<p>1 MR. ORENT: Objection.</p> <p>2 THE WITNESS: No. I mean, I explained 3 to you that I interpret based on what we know about 4 tissue reaction and general physiology of humans.</p> <p>5 BY MS. BYARD:</p> <p>6 Q. Okay. You also write that: 7 "Mesh in smooth muscle can 8 interfere with muscle contraction 9 and organ function."</p> <p>10 A. Yes.</p> <p>11 Q. Again, you haven't used any 12 imaging to test in human beings, how mesh present 13 with smooth muscle interferes with muscle 14 contraction or with organ function, have you?</p> <p>15 A. I'm not radiologist, I don't use 16 images -- what I see, I see when the mesh is in 17 the smooth muscle, I know it went all the way to 18 urinary bladder, it's somewhere in the detrusor 19 muscle. I mean, if the bundles are consistent with 20 bladder. It correlates almost 100 percent with 21 clinical descriptions of urinary symptoms.</p> <p>22 Q. So in answer to my question, no, 23 you haven't studied that in humans because you're 24 not a radiologist and that's not in your area of 25 study --</p>	<p>1 A. Well, then they measure forces and 2 pressures to understand what's causing urinary 3 symptoms.</p> <p>4 Q. And they measure the forces of 5 various intraabdominal contractions, or the 6 detrusor muscle contraction --</p> <p>7 A. Detrusor muscle, yes.</p> <p>8 Q. -- within the female body, right?</p> <p>9 A. Yes, there is --</p> <p>10 Q. That's not an area that you've 11 studied though, correct?</p> <p>12 A. No. No, I have not.</p> <p>13 MR. ORENT: Counsel, we're at 6:25, 14 we're going to wrap up in about five minutes.</p> <p>15 MS. BYARD: Okay. I might be at a good 16 stopping point then.</p> <p>17 BY MS. BYARD:</p> <p>18 Q. There's also a discussion here of 19 limited elasticity. And, similarly, there are ways 20 to study the elasticity of different tissues within 21 the body, aren't there?</p> <p>22 A. Yes, including gross examination, 23 which I do.</p> <p>24 Q. But there is testing that can be 25 done beyond gross examination, right?</p>

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<p>1 A. For my purposes, we are not doing 2 more than that as a pathologist. If it's done for 3 any other diagnostic procedures, I'm not aware of 4 commonly used diagnostic tool which would use 5 elasticity for a specific diagnosis. 6 Q. Well, researchers have looked at 7 the elasticity of virgin tissue compared to scar 8 tissue, haven't they? 9 A. Well, that's research. Research 10 and clinical practice are different areas, I 11 mean -- 12 Q. So irrespective of whether it's in 13 research or clinical practice, there are ways to 14 look at the relative elasticity of different types 15 of tissues? 16 MR. ORENT: Objection. 17 BY MS. BYARD: 18 Q. True? 19 A. Yes. I mean, mostly for research, 20 as I expect. Maybe there is a very limited amount 21 of clinical applications, like for genetic 22 conditions when there is not enough collagen or 23 something else, I mean, but -- 24 Q. Or with pelvic organ prolapse, 25 too, where there are different types of collagen</p>	<p>1 Q. Well, in a normal healthy person, 2 you wouldn't see pelvic organ prolapse to begin 3 with, would you? That's an abnormal finding? 4 MR. ORENT: Objection. 5 THE WITNESS: Partially, it's a 6 relaxation, age-related; so what do you mean? I 7 mean, healthy younger individual, yes, this would 8 be a problem. 9 BY MS. BYARD: 10 Q. Similarly, stress urinary 11 incontinence is an abnormal finding, isn't it? 12 A. Yes. 13 MS. BYARD: Okay, Doctor, I think we've 14 reached a good stopping point for the night. I 15 thank you for your time. 16 THE WITNESS: Thank you. 17 THE VIDEOGRAPHER: This marks the end 18 of media number four in today's proceedings in the 19 deposition of Dr. Vladimir Iakovlev. 20 We are going off the record at 6:31 p.m. 21 22 -- Whereupon the deposition was suspended at 6:31 p.m. 23 24 25</p>
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<p>1 present at different levels that lead to 2 abnormalities in the structures of the pelvis? 3 A. I don't think it is not. Pelvic 4 organ prolapse is just by visual assessment and 5 degree of prolapse. 6 Q. Do you know how the presence of 7 different types of collagen in the pelvic floor 8 correlate to incidence of pelvic organ prolapse in 9 women? 10 MR. ORENT: Objection. 11 THE WITNESS: Collagen alteration, the 12 ratios, I mean, they affect not just pelvic organ 13 prolapse, they affect the whole body. There will 14 be abnormalities, aortic dilatation and 15 hyperelasticity of joints and so forth. So it's 16 not just pelvic organs which are affected. 17 BY MS. BYARD: 18 Q. But that's not an area of your 19 study, right? 20 A. But this would be an abnormal 21 genetic condition, if we talk about collagen 22 alteration. 23 If it's a normal, healthy person, I 24 mean, there would not be collagen alterations 25 beyond what is normal expected with aging.</p>	<p>1 REPORTER'S CERTIFICATE 2 3 4 I, JUDITH M. CAPUTO, RPR, CSR, CRR, 5 Registered Professional Reporter, certify; 6 That the foregoing proceedings were 7 taken before me at the time and place therein set 8 forth, at which time the witness was put under oath 9 by me; 10 That the testimony of the witness and 11 all objections made at the time of the examination 12 were recorded stenographically by me and were 13 thereafter transcribed; 14 That the foregoing is a true and 15 correct transcript of my shorthand notes so taken. 16 17 18 19 Dated this 23rd day of December, 2014. 20 21 22 23 24 25 PER: JUDITH CAPUTO, RPR, CSR, CRR</p>

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Page 310	Page 312
1 CERTIFICATE OF REPORTER	1 ** ERRATA SHEET **
2 CANADA)	2
3 PROVINCE OF ONTARIO)	3 NAME OF CASE: IN RE: BOSTON SCIENTIFIC CORP.,
4	4 PELVIC REPAIR SYSTEM PRODUCTS LIABILITY LITIGATION
5 I, Judith M. Caputo, the officer before whom the	5 MDL NO. 2326
6 foregoing deposition was taken, do hereby certify	6 DATE OF DEPOSITION: DECEMBER 17, 2014
7 that the witness whose testimony appears in the	7 NAME OF WITNESS: VLADIMIR IAKOVLEV, M.D.
8 foregoing deposition was duly sworn by me; that the	8
9 testimony of said witness was taken by me in	9 PAGE LINE FROM TO
10 shorthand, using Computer Aided Realtime, to the	10
11 best of my ability and thereafter reduced to	11
12 written format under my direction; that I am	12
13 neither counsel for, related to, nor employed by	13
14 any of the parties to the action in which the	14
15 deposition was taken, and further that I am not	15
16 related or any employee of any attorney or counsel	16
17 employed by the parties thereto, nor financially or	17
18 otherwise interested in the outcome of the action.	18
19	19
20	20
21	21
22 Judith M. Caputo, RPR, CSR, CRR	22
23	23
24 Commissioner for taking	24
25 Oaths in the Province of Ontario	25 VLADIMIR IAKOVLEV, M.D.
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1 INSTRUCTIONS TO WITNESS	1 PROVINCE OF ONTARIO)
2	2 TORONTO REGION)
3 Read your deposition over carefully.	3
4 It is your right to read your deposition and make	4
5 changes in form or substance. You should assign a	5
6 reason in the appropriate column on the erratum	6 I, the undersigned, declare under penalty
7 sheet for any change made.	7 of perjury that I have read the foregoing transcript,
8 After making any changes in form or	8 and I have made any corrections, additions or
9 substance, and which have been noted on the	9 deletions that I was desirous of making;
10 following erratum sheet, along with the reason for	10 That the foregoing is a true and
11 any change, sign your name on the erratum sheet and	11 correct transcript of my testimony contained
12 date it.	12 therein.
13 Then sign your deposition at the end of	13
14 Your testimony in the space provided. You are	14
15 signing it subject to the changes you have made in	15 VLADIMIR IAKOVLEV, M.D.
16 the erratum sheet, which will be attached to the	16
17 deposition before filing. You must sign it in	17
18 front of a witness. The witness need not be a	18 Subscribed and sworn to before me this ____
19 notary public. Any competent adult may witness	19 Day of _____, 2014 at
20 your signature.	20 _____,
21 Return the original erratum sheet	21 (City) (Province)
22 promptly. Court rules require filing within 30	22
23 days after you receive the deposition.	23 _____
24	24 (Notary Public)
25	25 My Commission Expires: _____

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